Maternal and Child Health Services
Title V Block Grant

State Narrative for District of Columbia

Application for 2013
Annual Report for 2011

Document Generation Date: Monday, September 24, 2012

Table of Contents

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section. IA - Letter of Transmittal

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

These documents are available upon request.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

E. Public Input

Needs Assessment
There were several components to the Title V Needs Assessment: a contracted service to conduct quantitative data analysis, key informant interviews and focus groups to assess Maternal and Child Health needs in the District;
A Community Forum was convened on April 6, 2010, to seek stakeholder input on preliminary data gathered from the 2010 Needs Assessment in order to help rank DC Maternal and Child Health priorities. More than 60 participants attended, representing parents, providers, advocates, community organizations and government agencies. .Dr. Anjali Talwalkar opened the session with a welcome and overview of the Title V grant including objectives, funding requirements and current programs supported through Title V funds. The contractor, InterGroup Services, then presented an overview of the needs assessment process undertaken (the methodology is described in the attached needs assessment document) and shared key quantitative and qualitative findings. Participants were then asked to select a specific focus group to attend for more in-depth discussion and debate of potential priorities: Children/Youth with Special Health Care Needs, Child and Adolescent Health, or Perinatal and Maternal Health. The entire group was re-convened after the breakout sessions to rank priorities. The priorities that emerged from the Community Forum were the following: unintended pregnancies/teen births; decrease infant mortality; increase knowledge of available services; improve special health care needs diagnosis in schools; improve access to medical services; enhance nutrition/physical activity; increase recreational programs for youth; increase access to medical homes for CSHCN; increase access to prenatal care; and increase home visiting programs.
To supplement the Contractor's needs assessment efforts, CHA also utilized a variety of other mechanisms to identify Maternal and Child Health needs in the District and to gather input from community partners to help inform priority-setting, including multiple District-wide forums and several additional sources of data such as the Rand Corporation's 2009 Report Health and Health Care Among District of Columbia Youth, the National Survey of Children with Special Health Care Needs 2005/2006, the CDC's Breastfeeding Survey and the National Alliance to Advance Adolescent Health needs assessment.

The results of the Needs Assessment focus groups and communtiy imput helped to draft the 10 priorities

listed in Form 14.

Ongoing Communication with the Public
The Title V Needs Assessment and priority list will be found on the Title V website, a part of the CHA website off the DOH main page (http://doh.dc.gov/doh/site/default.asp).
The Office of the Deputy Mayor for Education continues to hold focus groups around children and youth health, education and development. Fall 2010, Children's National Medical Center is hosting three citywide Pediatric Forums for leaders throughout the District to come together to share resources and tackle pediatric issues collaboratively. Representatives from the Department of Health and the Title V program will participate in all these gatherings to promote Title V programs and services and to solicit feedback. The Title V program also convenes and participates on several advisory groups and committees to share information about maternal and child health programs and practices, including the Advisory Board for Children with Special Health Care Needs; the Advisory Committee for Perinatal, Infant and Interconceptional Health and Development; the DC Home Visiting Council; and the DC Council on Young Child Wellness. Town Hall meetings and focus groups are periodically convened to address specific MCH topics and are comprised of parents, advocates, adolescents, providers, and agency representatives for children and youth with special needs. CHA receives and reviews minutes and reports from these forums, using this information to support program decisions. For example, the Advisory Committee for Perinatal, Infant and Interconceptional Health and Development was instrumental in guiding the PIHB's social marketing campaign "I am a Healthy DC Mom."
DOH is working on a single Action Plan for DC that will be ready in Summer 2011 which will include the Title V action Plan. DOH is also working on completing Ward Level profiles that will be gender specific.
DOH has begun using Twitter and Facebook as social marketing tools which will be explored to enlighten the public about the priorities and funnel information about DOH programs out to the public, along with Photo Novellas; ethnic specific ads are currently used on the programmatic level to communicate with the public. //2012//

/2012/
CHA continues its efforts to engage the community in a dialogue about maternal and child health issues. A Maternal and Child Health (MCH) environmental scan was developed and distributed to community partners. The scan contained a list of the 10 Title V priorities (see Form14). Partners were asked to identify which priority they were focusing on, and to briefly describe objectives, outcomes and challenges.

Community participation was obtained at the MCH Community Forums convened on May 4 from 12-2 pm and May 12 from 6-8 pm. An evening meeting was added to accommodate those who could not attend the afternoon session. Child care and light refreshments were available at the evening session. Notice of the meeting had widespread distribution e,g, DC Funding Alert, the DC Primary Care Association and Metropolitan Washington Public Health Association (MWPHA) community calendars, emails to CHA collaborative partners, sub-grantees, advisory board members, publication in the DC Campaign to Prevent Teen Pregnancy newsletters and advertisement at health fairs, and through the DC Parent Information Network (DCPIN) listserv. Information was included in "Help DOH make plans for maternal and child health programs", April 27, Susie's Budget and Policy Corner (http://susiecambria.blogspot.com), which has a readership of more than 400 advocates, media and policymakers.

DOH is completing ward level profiles including discussion of race, age, and gender. DOH continues to expand its use of social marketing tools (Facebook, Twitter) as well as the more traditional communication techniques to enlighten the public about the MCH priorities and provide information about DOH programs. Social marketing efforts and educational materials were prepared to be culturally and linguistically competent to communicate public health messages to the public.//2012//

/2013/

The Community Health Administration (CHA) continues its efforts to engage the community in dialogues about the MCH population. In addition to participation in the numerous advisory groups, coordinating committees, and coalitions mentioned throughout this report, the Title V coordinator convened a meeting in April 2012 to review Title V-related activities in the CHA bureaus, the District Department of the Environment (DDOE) Lead Program, and the Department of Health (DOH), Addiction Prevention, Recovery, Administration (APRA), the HIV/AIDS, Hepatitis, STD, and TB Administration (HAHSTA), and the Health Regulation Licensing Administration (HRLA).
A community stakeholders meeting was first scheduled for May 24 and later rescheduled for June 18 and June 19. One meeting was held in the afternoon and the second in the evening in order to accommodate different work schedules. Notice of the meeting was distributed widely: DC Funding Alert; announcements in the DC Primary Care Association and Metropolitan Washington Public Health Association (MWPHA) community calendars; email to attendees at last year's stakeholders forum; email to sub-grantees; distribution through the Office of Special Education (OSE); CSHCN advisory board members; DC Parent Information Network (DCPIN) listserv; National Alliance for Adolescent Health Listserv; DC Tobacco Free Coalition Listserv; DC Lead and Healthy Homes Listserv. Information was also included in Susie's Budget and Policy Corner (http://susiecambria.blogspot.com),

At the forums the CHA Title V coordinator and the bureau chiefs described their programs. Approximately 10-15 individuals attended each forum. They ranged from long time service providers and family advocates to a grandfather who was completely unaware of the services available to his family. Most participants indicated they had previously heard about the 2010 decline in the infant mortality rate from recent media coverage. One attendee, representing a local foundation, advocated application of the approach taken over past decades to the reduction of infant mortality to obesity, saying that childhood obesity was a problem even more severe than infant mortality. Most of the attendees wanted more information about existing programs, pointing out that the DOH website does not contain current information and is not easily navigated. (Staff acknowledged the significance of the problem and said that department staff was in the process of revamping the website.) The Family Voices representative had a list of suggestions for new and/or improved services: emergency preparedness plan for CYSHCN, establishment of special needs registries for surveillance, greater engagement of faith communities, oral health services with a behavioral component or staff person for CYSHCN, provision of information on resources to parents prior to discharge from birthing hospitals, and greater participation of DOH staff in physical activity programs. Other attendees echoed suggestions for more accessible information about both direct and informational services along with information on eligibility criteria. Finally, one attendee expressed concern with the DOH sub-grant process, saying that announcements were sometimes issued and withdrawn without explanation and that follow up information was not always sent to applicants.

CHA continues to actively participate in and staff the Children with Special Needs Advisory Board meetings, where community stakeholders meet monthly to discuss emerging issues. At the June 19 forum, several participants, who said that they were unaware of the advisory board, requested information on membership. A membership application form was e-mailed to attendees the next day.

Taking a suggestion from the CSHCN advisory board, future dissesmination plans may include an executive summary of the Title V document, trend analysis of data, and/or additional community forums. Plans will be made to convene the internal stakeholders group and increase their collaboration. The advisory board will also help CHA increase public input by developing one or a series of parent foums.//2013//

II. Needs Assessment

In application year 2013, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

/2013/ The DOH needs assessment was completed in 2010. Tthe 10 priorities remain the same. As mentioned above, CHA and Children's National Medical Center (CNMC) worked with the Citywide Pediatric Forum in 2011 to complete a single action plan for CYSHCN. A final monograph is being reviewed by CNMC and will be released in the new fiscal year. Based on recommendations from community stakeholders who participated in the pediatric forum, a revised version of the Child Health Action Plan is planned in 2013. Although several other data collection and analyses efforts are underway and findings may suggest changes in needs, CHA has nothing additional to report at this time. //2013// An attachment is included in this section. IIC - Needs Assessment Summary

III. State Overview

A. Overview

The District has a unique status as the nation's capital and serves the multiple roles of a city, county and state. It consists of an urban land area of 63 square miles. Fifty-seven percent of the land base is tax-exempt, much of it owned by the federal government, and 41% of the assessed property value is exempt from property taxes, factors that impact upon the resources available to the District government for services to residents. Although DC residents elect a mayor and city council, they do not have voting representation in the US Congress, which has exclusive authority over legislative acts, including those pertaining to the budget. This status, combined with limitations of the local government's authority to tax federal and other property and incomes of commuters, severely limits the availability and allocation of resources.

The District's population has been growing steadily since 2000 with the most recent Census Bureau estimate in 2009 to 599,657. In 2008, the population distribution was 54.4% African American, 40.1% Caucasian, 8.2% Hispanic, 5.1% includes Native Americans, Alaskans, Hawaiians, and Pacific Islanders, 3.4% Asian, and 1.5% mixed (two or more races). The 2006 American Community Survey found that only 40% of current D.C. residents were born in the District, 16% below the national average.

District residents live in one of the eight Wards. Economic disparities are evident among all the wards. For example, Wards 6, 7, and 8 comprise the majority of African American residents (79.2%) and more than 30% live below the Federal Poverty Level (FPL). Wards 4 and 1 comprise a significant proportion of the Latino population (20.8%) with expansion into Wards 5 and 6, due to rapid economic development.

The Rand Study (January 2008) reported that health outcomes in adult District residents varied significantly across wards. 1) Ward 7 had the highest rates of hypertension, diabetes, any chronic condition, and poor or fair self-reported health. These rates were statistically higher than the mean rate for all of DC. 2) Rates of hypertension, diabetes, and overweight/obesity were also higher in Ward 8 compared to the city-wide average. 3) Ward 5 had higher rates of hypertension and overweight/obesity compared to the citywide average. 4) The highest rate of obesity was in Ward 8. Rates of obesity were higher in Wards 4, 5, 7, and 8 compared to the city as a whole. Nearly three out of every four adult Ward 8 residents reported a height and weight that classifies them as overweight. Among key findings related to nutrition, physical activity and obesity for children in the District overall are the following: 1) Seven percent of children were reported to have a health issue that limits their ability to perform the activities of most children. 2) Across the city, 36 percent of children between ages 6 and 12 were overweight, while 17 percent of children between ages 13 and 17 were overweight. The Rand Study reported that 4.1% of District parents report that their children have poor or fair health and 12.1% believe that their children require more medical care than other children.

About one-third of Washington residents are functionally illiterate (DC LEARNS August 2007 issue), compared to a national rate (one in five). This is attributed in part to Hispanic, Ethiopian, and Eritrean immigrants that make up 12.7 percent of the District's population but are not proficient in English. It is also important to note that 45 percent of D.C. residents have at least a four-year college degree, the fourth-highest rate in the nation, illustrating the social divide present in the city.

The health and well being of women and children in shelters, transitional homes and on the street continue to be a major concern of the DOH. The Community Partnership for the Prevention of Homelessness (CPPH) reports on behalf of the District of Columbia the Annual Homeless Assessment Report (AHAR) for the Department of Housing and Urban Development (HUD). The purpose of the data reporting is to identify gaps in services, understand the nature of homelessness and analyze Continuum of Care effectiveness and utilizations. In January 2008 CPPH reported the age distribution of the 11,562 individuals in shelters for the period from October 2006 - September 2007 as: Ages 13-17 (.03%); 18-30 (8.0%); 31-50 (39.6%), 51-60 (18.8%) and 62 and older (3.8%). The District of Columbia Homeless Services Reform Act (2005) redefined Hypothermia and Emergency Shelter as Severe Weather and Low Barrier Shelter to ensure that the District's homeless population had access to shelter in the event of severe

weather, such as extreme hot and cold temperatures, flooding and high winds.
The breakdown of single persons in the shelter system was 17 percent women and 83 percent men with a median length of stay at emergency shelters of 20 days. Twelve percent (12%) of homeless women and eight percent (8%) of homeless men stayed in shelter the entire year. One in ten persons in emergency shelter reported disabilities.
The number of families in the Emergency Shelter System was 1,661 persons in 507 families that were served in publicly funded emergency shelters in FY07; 1,008 of the persons served were children, accounting for 61 percent of the population and 77 percent of adult persons in families were female. The median length of stay for adults in family emergency shelter was 160 days; 20 percent of families served in FY07 were in shelters for the entire year and 40 percent of the adults in families served were living with family or friends before entering a shelter. Families in Transitional Housing accounted for 769 persons in 256 families that were served in publicly funded transitional housing for families in FY07; 480 of the persons served were children, or 62 percent; 89 percent of the adult persons in families were female. The median length of stay for adults in family transitional housing was 361 days; 53 percent of families served in FY07 were in shelters for the entire year. On an average night during the period, 75 percent of family transitional housing beds were occupied.
According to the DC Office of Planning's 2007 American Community Survey, the District had 13% of all its families in the past 12 months below the poverty line with 19.1% with related children under 18 years of age and 8.2% with related children under 5 years of age. It also stated that 26.9% of the District households did not have a husband present.
The District is broken down into eight wards based upon zip codes, boundaries, census tract and Council representation. Economic, social and health status indicators vary considerably across the 8 wards. The following is a summary of the health and socioeconomic profile of the 8 wards from the DC Department of Health State Center for Health Statistics, Center for Policy, Planning and Evaluation.
• Ward 1, a racially and ethnically diverse community, is centrally located in the heart of the District of Columbia. The majority of Ward 1 residents are working-aged adults who are employed in the civilian sector. Over 90% of Ward 1 residents possess some type of health care coverage. Over 66% of the population obtains health screenings for HIV and Cancer. Major health challenges include relatively high death rates due to essential hypertension and prevalence of HIV/AIDS. Health risk behaviors include obesity and binge alcohol consumption.
• Ward 2 is bordered by the Potomac River to the west and is located primarily in the southwestern section of the District of Columbia. A racially and ethnically diverse community, the majority of its residents is working aged adults who are employed in the civilian sector. In the area of health care access, almost 95% of Ward 2 residents possess some type of health care coverage. Over 70% of residents have received screening for breast or prostate cancer. Major health challenges include the relatively high death rates due to essential hypertension and HIV/AIDS. Upon examination of health risk behaviors, over 90% of Ward 2 residents are engaging in some physical exercise and over 55% are maintaining a healthy weight. However, a comparatively high number are consuming dangerously high amounts of alcohol. A relatively high percentage (12%) of Ward 2 residents reported having physician diagnosed asthma.
• Ward 3 is located in the northwestern section of the District of Columbia. The community has a majority white population (80%) with a population of Blacks and Hispanics slightly above 6%. Almost 80% of Ward 3 residents have attained Bachelor's degree level education or higher. In the area of health care access, over 95% of Ward 3 residents possess some type of health care coverage. Over 78% of residents have received screening for breast or prostate cancer. Major health challenges include the relatively high death rates due to heart disease and essential hypertension.
• Ward 4 is located in the northernmost tip of the District of Columbia. A predominantly African-American community with a growing Hispanic population, the majority of its residents is working-aged adults who are employed in the civilian sector. In the area of health care access, about 93% of Ward 4 residents possess some type of health care coverage. While over 85% of residents have been screened for breast cancer, only 57% have been screened for prostate cancer. HIV screening has been conducted for over 70% of the Ward 4 population. Major health challenges include the relatively high death rates due to heart disease, cancer and essential

hypertension.
• Ward 5 is located in the northeastern quadrant of the District of Columbia. A predominantly African-American community, the majority of its residents is working-aged adults who are employed in the civilian sector. In the area of health care access, about 85% of Ward 5 residents possess some type of health care coverage. Over 82% of female residents have been screened for breast cancer and over 72% of male residents have been screened for prostate cancer. HIV screening has been conducted for over 73% of the Ward 5 population. Major health challenges include the relatively high death rates due to heart disease, cancer and essential hypertension. Homicide is the sixth leading cause of death among Ward 5 residents.
• The boundaries for Ward 6 cross all four quadrants of the District of Columbia. A racially diverse community with a growing Hispanic population, the majority of its residents is workingaged
adults who are employed in the civilian sector. In the area of health care access, about 91% of Ward 6 residents possess some type of health care coverage. While over 82% of female residents have been screened for breast cancer, only 68% of male residents have been screened for prostate cancer. HIV screening has been conducted for over 71% of the Ward 6 population. Major health challenges include the relatively high death rates due to heart disease, cancer and essential hypertension. A health risk of concern is the relatively low percentage of persons within a healthy weight range.
• Ward 7 is located in the eastern most tip of the District of Columbia. A predominantly African-American community, almost 30% of the population is 19 years old or younger. In the area of health care access, about 86% of Ward 7 residents possess some type of health care coverage. Approximately 78% of female residents have been screened for breast cancer and over 67% of male residents have been screened for prostate cancer. HIV screening has been conducted for over 70% of the Ward 7 population. Major health challenges include the relatively high death rates due to heart disease, cancer, diabetes and essential hypertension. Homicide is the fifth leading cause of death. Health risk behaviors of concern include obesity, lack of physical activity and current smoking.
• Ward 8 is located in the southern most tip of the District of Columbia. A predominantly African-American community, almost 40% of the population is 19 years old or younger. In the area of health care access, about 88% of Ward 8 residents possess some type of health care coverage. Approximately 77% of female residents have been screened for breast cancer and over 67% of male residents have been screened for prostate cancer. HIV screening has been conducted for over 80% of the Ward 8 population. Major health challenges include the relatively high death rates due to HIV/AIDS and essential hypertension. Homicide is the fourth leading cause of death. Health risk behaviors of concern include obesity, lack of physical activity and current smoking.
The District has seven birthing hospitals and one birthing center that provide obstetrical and/or neonatal services, four of which provide tertiary care for deliveries and neonates: Georgetown University Hospital (tertiary), George Washington University Hospital (tertiary), Washington Hospital Center (tertiary), Howard University Hospital (tertiary), Providence Hospital, Sibley Hospital, United Medical Center and DC Birth Center. The District also has 30 Community Health Centers and 48 Primary Care Health Centers.
The three Managed Care Organizations (MCOs) are mandated to provide case management services to high-risk pregnant women. These women are only identified for services after they have presented to a provider for care and therefore are sometimes missed for referral for case management.
Presently there are three Healthy Start programs in the District. Two of the programs are overseen by the Department of Health and the remaining program is managed by Mary's Center, a Federally Qualified Health Center that provides primary care and enabling services to underserved and underinsured immigrants primarily from Latin America, the Caribbean, Africa, the Middle East, and Asia. These programs provide outreach and client recruitment, case management and health education to the District's high risk pregnant and postpartum women and their infants. Even though services are available to promote healthier birth outcomes, some of the Districts residents and medical providers do not have information about these services. This is thought to be a result of the transiency of the District's residents and provider turnover.

Fortunately, the District has an MCH administrator, department colleagues, collaborators and the city council who keep their fingers on the pulse of the city and who recognize the importance of convening public meetings with stakeholders to collect input and develop effective strategies for program and policy implementation. Emerging issues for the city which will impact Title V include: 1) the impact of new health care reform initiatives which will expand access to health insurance programs for District residents; 2) a high incidence of sexually transmitted infections (STI) among youth requiring enhanced STI prevention and primary care; 3) pediatric health issues related to overweight/obesity; and 4) increasing youth violence and truancy. The District is evaluating a host of strategies to address this latter issue, including the possibility of early, targeted mental health interventions and services, the expansion of high school based health centers (medical homes); juvenile justice reforms, and increased accountability for parents and guardians. The most recent efforts to address the needs of District residents that will support and enhance the efforts of the Title V grant include: 1) In 2010 the District will add three new high school based health centers bringing the total to five (5). 2) The Youth Sexual Health Project is a new priority requiring coordination with District of Columbia Public Schools, District Department of Environment, Department of Youth Rehabilitation Services, District youth, and community-based providers to implement the Project's recommendations. 3) The National Institutes of Health announced the new D.C. Partnership for HIV/AIDS Progress, a collaborative research initiative between NIH and the Department of Health designed to decrease the rate of new HIV infections in the city, improve the health of District residents living with HIV infection, and strengthen the city's response to the HIV/AIDS epidemic. The partnership is being co-led by the National Institute of Allergy and Infectious Diseases (NIAID), part of NIH, and the D.C. Department of Health. 4) DOH has launched the Live Well DC campaign (LWDC), an interagency effort to create a holistic approach to health and wellness by targeting individual behaviors that result I n poor health outcomes. LWDC aims to improve the health of those in our community, and ensure that District residents live longer, more productive lives by encouraging residents to follow 10 Healthy Living Tips. 5) The city also recently purchased United Medical Center, the only hospital serving residents east of the Anacostia River to ensure continued access to health care. 6) The DC Home Visitation Council has been rejuvenated and DOH is an active participant.

/2012/
The 2010 United States Census reports that the total population for the District of Columbia was 601,723 residents, an increase of 5.2% between decennial census years (from 572,059 in 2000 to 601,723 in 2010). The District is geographically divided into four quadrants (northeast, northwest, southeast and southwest) and eight electoral wards. Changes in the wards are noted below.
Located in the northwest quadrant of the city Wards 1 and 4 are home to most of the District's Hispanic population; while Wards 5 and 6 are located in the northeast quadrant of the city and are predominantly African--American. The residents of Wards 7 and 8, have experienced the greatest population decreases, and are smaller in number as compared to the remaining wards in the District. Due to population shifts, the District will redefine the boundaries of Wards 2, 6, 7 and 8 to create an even population distribution, as required by District law, before the end of 2011.

Wards 7 and 8 are predominantly comprised of English-speaking, African-Americans with a high percentage of residents who fall below the federal poverty level although many are employed. There is also a significant shortage of health care specialists in pediatrics, behavioral health, and substance abuse is located within these wards. Individuals and families residing in Wards 7 and 8 also suffer disproportionately from a number of chronic health conditions, including heart disease, cancer, HIV/AIDS, diabetes, and chronic respiratory diseases. Children in these wards have higher prevalence of asthma, poor nutrition, and a host of behavioral health conditions.

The mission of the DC Department of Health Community Health Administration (CHA) remains unchanged: to improve health outcomes for women, infants, children and adolescents including children and youth with special health care needs. Within CHA the Maternal and Child Health priorities are covered by two main bureaus. The Perinatal and Infant Health Bureau (PIHB) focuses on women before, during, and after pregnancy, as well as infants from age 0 to 2 years

old. The Child Adolescent and School Health Bureau (CASH) focus is on children from preschool to school age to adolescence (3-21) and children and youth with special needs (3-26).

PIHB released a social marketing campaign in May 2009. Its contractor designed and implemented a comprehensive marketing campaign and strategy that addresses poor prenatal outcomes and disparities and other specific health outcomes for mothers and babies that include infant mortality, very low and low birth weight, preterm birth, birth defects, and SIDS. The contractor also produced three thirty second Public Service Announcement (PSA) and one 15 minute video for dissemination to various community groups, service providers, and other venues. The campaign's PSA and video had 3 key messages, "I will stay fit and eat right"; "I will commit to 40 weeks"; and "I will keep my baby safe and healthy." The Healthy Mom and Baby campaign will be extended in 2011 to include "I am a Healthy DC Dad."

During infant mortality month (September 2010), CHA launched the "I am a Healthy DC Baby" public information campaign. Materials related to this campaign emphasize what parents can do to have a healthy baby and where to call to obtain more information and support. Its four subthemes are: "I have my daily needs met"; "I am fed healthy foods"; "I get scheduled health check-ups"; and "I am safe where I sleep and play".

New programs to address maternal and child health included the HRSA First Time Motherhood/New Parents Program (FTMP). FTMP mission is to educate new and prospective parents about the effect of life choices on birth outcomes through the following objectives: (1) implement a statewide public awareness campaign of the effects of life choices on birth outcomes; (2) increase providers' and high school students' knowledge of the importance of integrating the life-course perspective into their preconception/ interconception care; (3) increase public awareness of parental responsibility; (4) increase public awareness of family support and education programs for expectant and new parents; and (5) increase male partners' awareness of risky behaviors on birth outcomes. The program is in year one of a three year demonstration grant.

CASH in collaboration with PIHB's DC Healthy Start Project will implement evidence based models for home visitation including Project LAUNCH (Linking Actions for Unmet Needs in Children's Health), a 5-year initiative (ending its 2nd year). Project Launch's goal is to promote the wellness of young children (0 -- 8 years in Wards 7 and 8) so they can thrive in safe, supportive environments and enter school ready to learn. Project LAUNCH brings local child-serving agencies together to coordinate and streamline policies and practices for families and children most in need, and to fill service gaps where they exist. The DC Council on Young Child Wellness (DCCYCW) was developed to oversee all LAUNCH activities.

In FY 2011, DOH was awarded funds to administer the Maternal, Infant and Early Childhood Home Visiting Program (MIECHVP). The MIECHVP is designed to (1) strengthen and improve the programs and activities carried out under Title V; (2) improve coordination of services for at-risk communities; and (3) identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities. DC early childhood home visitation services will be centered in Wards 5, 7 and 8. These where defined as "at-risk communities" with high concentrations of premature birth, low-birth weight infants, and infant mortality, including infant death due to neglect, or other indicators of at risk prenatal, maternal, newborn, or child health; poverty; crime; domestic violence; high-school dropouts; substance abuse; unemployment; and child maltreatment. A combination of two home visitation models will be used: Parents as Teachers (PAT) targeting mothers prenatally as well as children birth through three years old; and Home Instruction for Parents of Preschool Youngsters (HIPPY) targets children ages three to five years old and focuses on parental involvement, and school readiness of the target population.

CASH issued a grant to develop a DC Parent Information Network (DC PIN) to increase access to medical homes for children with special health care needs supporting seamless systems of care and transition across service systems.

In FY11, the Pediatric Citywide Community Health Forum was convened to develop and implement a shared priority agenda addressing the health needs and concerns of District children. Seven priority areas were identified: Asthma; Injury Prevention/Violence; Mental Health (Developmental Delays and Substance Abuse); Obesity/Overweight; Oral Health; Sexual Reproductive Health (STI's, Teen Pregnancy, HIV); and Systematic Issues-Built Environment. One of the products of the health forum is a Comprehensive Action Plan to which all the workgroups will contribute. The Sexual Reproductive Health work group completed a Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis and is completing a community health needs assessment for the health plan. The Pediatric Oral Health Coalition was formed as a result of the Citywide Pediatric Forum, seeking to involve all Pediatric Providers of oral health services in the city with future plans for an oral health community needs assessment.
The SSDI grant is designed to complement the Title V Maternal and Child Health (MCH) Block Grant Program, and assist programs centered on MCH populations including children with special health care needs to build and improve MCH data infrastructure. In the FY 2012 -- FY2016 cycle the Community Health Administration will develop a comprehensive strategy that leads to better and more timely data, and use data to stimulate smarter program planning, improve monitoring capability, and use evaluation to provide timely feedback to program planners and stakeholders. Some MCH data systems have limited reporting capabilities and are not accessible to manages, planners and analysts. Developing monitoring systems has proven problematic and makes follow-up activities labor intensive. Bureaucratic challenges exist between stakeholders leading to data not being available in a timely way

The Oral Health Program provides preventive oral health service education to elementary students of participating DCPS and DC Charter Schools and Head Start Centers. These services include dental exams, cleanings and sealants, oral health education and promotion and referrals to outside dentists. Special emphasis is made to provide sealants to 2nd and 3rd graders. The Program also provides oral health education and promotion to all students in the participating schools that are age appropriate, including pre and post oral health seminar tests on knowledge of preventive oral health hygiene practices. The goal of this effort is to increase oral health literacy. The school based dental program promotes dental services and identify dental providers to provide invasive and comprehensive dental treatment services to children who are referred with a need for more comprehensive and urgent care.

In FY10 an existing memorandum of understanding between DOH and DCPS/OSSE was strengthened to expand the scope of work of dentists in DC public and Charter schools. The new agreement enables the program to increase the capacity to have more children receive oral health care by expanding access to direct oral health care services at various schools from preventive to simple tooth (teeth) extractions and fillings using local anesthesia.

The mission of the Nutrition and Physical Fitness Bureau (NPFB) supports Title V efforts by providing breastfeeding peer counselors, lactation consultants, and breast pumps for new moms. Through NPFB's SNAP-ED (Special Nutrition Assistance Program Education), provides nutrition education, and food and physical activity demonstrations to residents potentially eligible for SNAP. In FY 2010, SNAP-ED education lessons began to more strongly emphasize its physical activity component to customers.

The District's Healthy Schools Act (HSA) of 2010 continues to expand implementation of healthier nutrition standards and food offerings, and is now trying to work more strongly on developing demand for healthy foods among students; beginning a program encouraging and expanding school gardens, bringing School Gardens Specialists to provide support for this effort; continuing to monitor vending machines offering healthy snacks; and expanding its After-school supper program, now in 99 public and charter schools and another 30 Department of Parks and Recreation (DPR) and YMCA sites. Additionally, schools must comply with meeting minimum levels of physical activity and education requirements with provisions for including students with special needs, disabilities, chronic health challenges and to ensure that physical activity or denying it is not used as a punishment. HSA has allowed Breakfast in the Classroom, which has

helped to increase the numbers of children consuming breakfast with its associated benefits.

Presently there are three Healthy Start programs in the District. Two of the programs are overseen by the Department of Health and the remaining program is managed by Mary's Center, a Federally Qualified Health Center that provides primary care and enabling services to underserved and underinsured immigrants primarily from Latin America, the Caribbean, Africa, the Middle East, and Asia. These programs provide outreach and client recruitment, case management and health education to the District's high risk pregnant and postpartum women and their infants. Even though services are available to promote healthier birth outcomes, some of the Districts residents and medical providers do not have information about these services. This is thought to be a result of the transiency of the District's residents and provider turnover. Fortunately, the District has an MCH administrator, department colleagues, collaborators and the city council who keep their fingers on the pulse of the city and who recognize the importance of convening public meetings with stakeholders to collect input and develop effective strategies for program and policy implementation. Emerging issues for the city which will impact Title V include: 1) the impact of new health care reform initiatives which will expand access to health insurance programs for District residents; 2) a high incidence of sexually transmitted infections (STI) among youth requiring enhanced STI prevention and primary care; 3) pediatric health issues related to overweight/obesity; and 4) increasing youth violence and truancy. The District is evaluating a host of strategies to address this latter issue, including the possibility of early, targeted mental health interventions and services, the expansion of high school based health centers (medical homes); juvenile justice reforms, and increased accountability for parents and guardians. The most recent efforts to address the needs of District residents that will support and enhance the efforts of the Title V grant include: 1) In 2010 the District will add three new high school based health centers bringing the total to five (5). 2) The Youth Sexual Health Project is a new priority requiring coordination with District of Columbia Public Schools, District Department of Environment, Department of Youth Rehabilitation Services, District youth, and community-based providers to implement the Project's recommendations. 3) The National Institutes of Health announced the new D.C. Partnership for HIV/AIDS Progress, a collaborative research initiative between NIH and the Department of Health designed to decrease the rate of new HIV infections in the city, improve the health of District residents living with HIV infection, and strengthen the city's response to the HIV/AIDS epidemic. The partnership is being co-led by the National Institute of Allergy and Infectious Diseases (NIAID), part of NIH, and the D.C. Department of Health. 4) DOH has launched the Live Well DC campaign (LWDC), an interagency effort to create a holistic approach to health and wellness by targeting individual behaviors that result I n poor health outcomes. LWDC aims to improve the health of those in our community, and ensure that District residents live longer, more productive lives by encouraging residents to follow 10 Healthy Living Tips. 5) The city also recently purchased United Medical Center, the only hospital serving residents east of the Anacostia River to ensure continued access to health care. 6) The DC Home Visitation Council has been rejuvenated and DOH is an active participant.
//2012//

/2013/
The Department of Health received a 3-year CDC grant as part of the National Public Health Improvement Project. Funding and technical assistance is helping the department to apply for accreditation. Part of that process is to develop a structure and process for department-wide performance management. At this time, the department's performance management is governed by local performance based budgeting requirements. Underneath those requirements, managers develop an annual performance plan and an annual performance accountability report, which are submitted to the Mayor and City Council for dissemination to the public. The District is in the process of finalizing the design and implementation of a new city-wide performance measurement plan. The plan will include citywide goals and objectives relative to all areas of municipal oversight. All agencies will be developing individual performance measures that coincide with the Districts' goals. The Department of Health is actively engaged in developing and finalizing their performance management plan which includes wellness and intervention health care

services that also includes the intended Title V population. A system is being designed to establish standards, develop measures, report progress and improve upon performance. DC's Healthy People 2020 Plan will form the basis for standards and for the community health assessment and the community health improvement plan required for accreditation. The community health improvement plan will set the direction for the entire city; staff will use this document to create a more narrowly focused document for the department's strategic plan, which is also required for accreditation and will be formed with input from front line employees, middle managers and leadership. Several department-wide workgroups have been convened and trained. Two quality improvement projects are underway, one of which is to improve the adherence of staff to grants management policies and procedures for improved use of resources.

Presently, there are two MCOs for the general Medicaid-CHIP population--Chartered Health Plan and United Healthcare Community Plan. Contracts are scheduled for re-competition for 2013. A third MCO, Medstar, will be serving Medicaid beneficiaries as of October. In additgion Health Services for Children with Special Health Care Needs, provides services for children and youth who qualify on the basis of disability status. They may select the MCO or fee-for-service. With local dollars, the District also funds the DC Health Care Alliance, which provides medical care for adults and children not otherwise eligible for Medicaid or CHIP. The Medicaid and Alliance programs, administered by the Department of Health Care Finance, fund health care services for approximately 200,000 persons, nearly 1/3 of the city's population.

Healthcare finance reform is progressing rapidly in DC. The District moved swiftly to implement the federal Patient Protection and Affordable Care Act (PPACA) which requires each state and the District to establish a benefit exchange to provide a health insurance marketplace where residents can compare and purchase insurance. The District hasl establish a quasi-governmental entity to operate its exchange. The nominations to site on the executive board waere announced by Mayor Vincent Gray June 2012. Mohammed Akhter, MD, Director of the DC Department of Health, will take a leave of absence to participate on the executive board. The Department of Human Services, along with DHCF, is planning for the implementation of a new integrated health and human services system in the District of Columbia, called the DC Access System (DCAS). DCAS will provide all of the health benefit exchange functions required by the PPACA as well as automated state-of-the-art health and human services eligibility, enrollment and case management functions. The new system will be web-based and will serve individual consumers, qualified employers and their employees, navigators and other assistors, health plan providers, brokers and agents, and designated DC government workers.

The DCAS is designed to offer residents a one-stop portal to access health and human services benefits and to:

- ***Create an insurance marketplace for individuals and employees;***
- ***Replace the District's aging eligibility determination and enrollment platform with a modernized, rules-based engine;***
- ***Integrate with federal and state data hubs to support real-time verification for eligibility applications;***
- ***Support new plan management and financial management processes for the health benefit exchange;***
- ***Redesign, expand and integrate Medicaid and human services case management functionality;***
- ***Design and implement a robust consumer friendly, web-portal presentation;***
- ***Integrate both current and new, consumer contact center operational and technical infrastructures; and***
- ***Design oversight and governance rules, guidelines, and policies.***

DCAS will provide horizontal program integration so that consumers can apply for subsidized commercial health insurance and/or public benefits including Medicaid, CHIP,

Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance to Needy Families (TANF), and other housing, employment, training, energy, nutrition and health care assistance programs. Announcement of the contractor is scheduled for July 2012.

The School Health Nursing Program collaborated with DC Public Schools to ensure the youngest students were provided hearing screenings. In SY 2011-2012, over 5100 pre-school, pre-K, and kindergarten students were screened. 193 students failed, and 16 students were referred for follow-up. In SY 2010-2011, this collaboration allowed over 4000 students to be screened for vision and hearing. This summer staff is working with Head Start child development centers to ensure that every enrollee receives a vision, hearing and oral health screen.

Within the Child Adolescent and School Health Division (CASH), the Oral Health Program provides preventive oral health service education to participating Head Start Centers, DCPS and DC Charter Schools. These services include dental exams, cleanings and sealants, oral health education and promotion, and referrals to outside dentists. Special emphasis is made to provide sealants to 2nd and 3rd graders. The program also provides oral health education and promotion to all students in the participating schools that are age appropriate, including pre and post oral health seminar tests on knowledge of preventive oral health hygiene practices. The goal of this effort is to increase oral health literacy. The school-based dental program promotes dental services and identifies dental providers to provide invasive and comprehensive dental treatment services to children who are referred with a need for more comprehensive and urgent care. The school-based health centers also offer dental services. In addition in FY 2012, the DOH funded the establishment of two school based health clinics with Federally Qualified Health Centers (FQHC). Within these new sites, oral health/dental services are available to all students with parental consent to receive oral health services regardless of their ability to pay. Management is working toward the establishment of an oral health division in the coming fiscal year.

During the past few years population change in the District has accelerated. In December 2011 the U.S. Census Bureau announced that among states and "equivalents" the District of Columbia had experienced the greatest percent (2.7%) increase in population between April 1, 2010, and July 1, 2011 for an estimated population of 617,996 (http://www.census.gov/newsroom/releases/archives/population/cb11-215.html). From 2000 to 2010 the African American population declined by 38,000 and the Caucasian population grew by about 50,000; the African Americans are no longer in the majority in the District. As noted at the One City Forum February 11, 2012, the districts population is 48% African American. Although city officials have recognized the benefits of an increase in the number of young professional tax payers, they acknowledge that not all residents have benefited by the relatively strong DC economy. In fact, an analysis by the DC Fiscal Policy Institute suggests that income inequality continues to increase. The richest 5% of District households have an average income of $473,000, the highest among the 50 largest cities in the United States: the poorest 20% have incomes averaging under $10,000. This gap between rich and poor is the third highest among the nation's largest cities with official poverty at 19.2%. (http://www.dcfpi.org/wp-content/uploads/2012/03/03-08-12incomeinequality1.pdf)

In May 2012 the release of the 2010 birth and infant death report indicated an infant mortality rate of 8 per 1000, a decline from 9.9 per 1000 in 2009. This overall reduction in infant mortality is explained by large declines in infant deaths to African American mothers. Since 2001, the African American IMR fell from 14.5 to 10.7 in 2010. Pregnancy rates decreased very slightly between 2009 and 2010 for women less than 15 years of age and women aged 15-19 years. The birth rate for the latter age group changed from 47.6 in 2009 to 45.4 in 2010. More analysis of birth and pregnancy rate changes is provided in the performance measures section of this report.

(http://www.dchealth.dc.gov/doh/frames.asp?doc=/doh/lib/doh/services/administration_offices/schs/pdf/reported_pregnancy_rates_in_dc_2006-2010_6_04_12_(v4).pdf)

On June 20, 2012 city officials announced that the HIV prevalence rate had been readjusted downward to 2.7%. The number of new infections had declined as well as the number of AIDS cases. The number of newly diagnosed HIV cases attributable to injection drug use declined by 72% from 2007 -- prior to the scale up of DC's needle exchange program -- to 2010. Of diagnosed cases, 2,730 HIV cases or 60% achieved viral suppression although many fewer persons maintained suppression. http://newsroom.dc.gov/show.aspx?agency=doh&section=2&release=23473&year=2012&file=http%3a%2f%2fdoh.dc.gov%2fdoh%2flib%2fdoh%2fservices%2fadministration_offices%2fhiv_aids%2fpdf%2fHAHSTA_ANNUAL_REPOR_2012.pdf

On October 28, 2011, the CHA Perinatal and Infant Health Bureau (PIHB) convened a one-day conference entitled Improving Birth Outcomes through the Life Cycle, one of the first local attempts to introduce the life cycle concept to maternal and child health stakeholders. More than 100 health and social services providers and community leaders attended. Discussions at the conference stimulated support for what subsequently became the I Care About Me campaign, a social marketing and traditional media public awareness campaign directed at African American and Latino youth aged 16-23 "who have yet to conceive". Health and wellness messages are sent out via Twitter. The campaign was launched in May 2012 at the Deanwood Recreation Center with District wide and community support. The media launch featured Department of Health officials in conjunction with local radio, TV, culinary and fitness personalities that interacted with the attendees to promote healthy lifestyle messages and featuring hands on activities and demonstrations.

In FY 2012 the CHA Primary Care Bureau continued to administer local funds to support the construction of new primary care sites that serve maternal and/or child populations. Five major projects have been completed to date using the District's funding - totaling over $90 million - in the last four years: considerable expansion of safety net primary care facilities has occurred, including but not restricted to the FQHC's operating in Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas (MUAs). In FY 2011, funds supported the following clinics: Bread for the City (1525 7th St. NW; Ward 2), Mary's Center for Maternal and Child Care (3910 Georgia Ave NW; Ward 4),; Kids Smiles Pediatric Dental Clinic (4827 Benning Road SE; Ward 7), and; Children's National Medical Center Satellite Pediatric Emergency Department (1310 Southern Ave SE; Ward 8). In FY12, two additional federally-qualified health center (FQHC) sites started construction, and completion of these new sites is scheduled for fall 2013.

DOH is in the process of collecting, compiling and analyzing the utilization data from the health centers constructed with DOH Tobacco Settlement Funds to assess their impact on access to care for DC populations, including the MCH population. A report on the capital projects is scheduled for release in FY 2013.

In addition to supporting capital expansions, DOH also provided operating funds to sites serving maternal and/or child populations. DOH continued to provide local funding to the District's largest FQHC - for and covered the fixed costs associated with - the operationg of five primary care health centers that serve maternal and child populations. In FY11 these sites provided services to 16,756 unduplicated patients aged 21 and younger. In addition, DOH provided funding for the operation of 3 School-Based Health Centers operated by both FQHCs and local hospitals. In FY11, the SBHCs supported by DOH provided services to 800 students.

CHA in FY 2012 also continued partnership/funding started in FY11 The DOH also continued funding and collaborating with Children's National Medical Center to provide

health education and primary care referral services to children and families utilizing the Ward 8 pediatric emergency department. In addition to funding the provision of these services, the DOH is also funding a three-year evaluation of the effectiveness of these services and of the root causes of families' inappropriate use of emergency services.

In addition, collected, compiled and analyzed utilization data from health centers constructed with DOH Tobacco Settlement Funds to assess their impact on access to care for DC populations, including the MCH population. CHA also assisted with the identification and development of sites for new school-based health centers. A report is scheduled for release in FY 2012. Two additional community based health centers are scheduled to open in the fourth quarter of FY 13, bringing the total number of centers to 6.

In FY 2013, DOH will sponsor a Primary Care Fair to further assist DC residents, including maternal and child health populations, in finding a medical home and linking to other health services including Healthy Start and WIC. DOH will also be launching an interactive map in early FY13 to assist DC residents and case managers in identifying primary care providers appropriate to individuals' needs.

CHA is again sponsoring 4 summer camps for CSHCN from June 1 through September 30, 2012. The campers must be DC residents and have special needs. The camps include: Breathe DC camp for asthmatic children; Advocates for Renewal in Education (ARE), a therapeutic camp for children with developmental, emotional, and socially disabling behaviors including Autism, ADHD, ED, MR, Bi-polar, and Down's Syndrome; HSCSN summer respite camp; and Brainy Camps, a series of 10 CSHCN camps covering the following conditions Tourette's Syndrome, Asperger's Syndrome, Congenital Heart Disorders(including Pacemakers, Arrhythmias, and ICDs), Youth in Transition with Epilepsy, Children and Teens with Neurofibromatosis, Children and Teens with Hemiparesis and other Hemiplegic and Diplegic Cerebral Palsy, Children and Teens with Down Syndrome, Adolescents and Teens with Type 1 Diabetes, and Children/Teens with Sickle Cell Anemia.

CHA has partnered with the DC Department of Parks and Recreation to provide nursing services at two summer camp locations. These sites are the Therapeutic Recreation (TR) Center located in Ward 7, and the Ferebee-Hope Recreation Center in Ward 8. The TR Center serves District residents with disabilities. Ferebee-Hope serves all children, but was identified as a site with a large number of campers with various medication needs.

The DOH Immunization Program collaborates with the District's public, private and parochial schools to support immunization compliance. The Immunization Registry is available via read-only access for immunization status review. The registry allows school nurses to identify those students who are out of compliance and provide that documentation to parents/guardians and school administrations. The Immunization Program notifies providers, school nurses, and education partners of any immunization requirement updates. The Immunization Program is responsible for administering the Vaccines for Children (VFC) Program. This CDC funded program is available to children who qualify for Medical Assistance only.

The Immunization Program won 3 National Immunization Survey (NIS) Awards in 2012. "State with the Highest Childhood Immunization Coverage" -- 80.8%; "State with the Highest Adolescent Immunization Coverage" -- which includes 1 dose of HPV (among girls) for adolescents ages 13 -- 17 years; and highest coverage for pneumococcal vaccine for high risk adults 18-64 years Adult -- 35.2%.

In August 2012, DC Department of the Environment (DDOE) was the recipeint of the Environmental Council of the States (ECOS) Program Innovation Award for the RiverSmart Program and the Healthy Homes Program.

The District began the Live Well DC (LWDC) interdepartmental, citywide healthy living initiative in an effort to educate the public, and increase public awareness of the importance of making healthy lifestyle choices. Projects, for example, include a health impact assessment of the 11th Street Bridge Project by the Office of Planning-The 11th Street Bridge Recreation and Destination is an exploration of design concepts for creating a new waterfront and adventure recreation attraction for the entire District in heart of the Southeast part of the city. If realized, the bridge would help unify the waterfront neighborhoods of Wards 6, 7 and 8, and be a hub connecting parks, trails, and recreation assets up and down both sides of the Anacostia River promoting physical activity for District residents and tourists; the exploration of possibilities of third party reimbursement for community based physical activity and nutrition education by the Department of Health Care Finance; and the identification of policies that may pose barriers to wellness, such as the public housing authority's ban of farmer's markets and mobile markets on its properties. Ward-based coaches are used to promote Move More activities. //2013//

An attachment is included in this section. IIIA - Overview

B. Agency Capacity

The Community Health Administration (CHA) is the administration within the DC Department of Health (D0H) that administers the Title V Maternal and Child Health Block Grant. The mission of the administration is to improve health outcomes for targeted populations by promoting coordination across systems of care; by enhancing access to prevention, medical care and support services; and by fostering public participation in the design and implementation of programs for District of Columbia women, infants, children (including children and youth with special health care needs) and other family members. Consequently, while Title V does not fund all activities within the administration, many of its programs touch the MCH population, and where appropriate, program linkages are made to maximize the benefit to this population. The DOH's capacity to provide preventive and primary care services for pregnant women, mothers, infants, children, including children and youth with special health care needs, is evidenced in its policies, programs, and grants and collaborations with government and agencies.

Key partnerships emerge from the existing networks of agencies, groups, organizations and individuals who are already involved in maternal and child health work. CHA has developed strong partnerships with other District government entities such as the local Public School System, the Department of Health Care Finance who oversees Medicaid for the District, the Department of Parks and Recreation, the Child and Family Services Agency, the Department of Mental Health, and the Department of Human Services to name a few. These partnerships have also been extended to local colleges and universities as well as community-based youth service agencies. The synergy that exists among these entities serves to integrate services and systems for adolescents and youth to avoid duplication of resources and to ensure that District of Columbia youth are healthy and able to succeed. For example, the Department of Human Resources funds school-based programs for pregnant/parenting teens in DC Public Schools. The Department of Health Title V program funds clinic-based programs for pregnant/parenting teens at major hospital centers such as Children's National Medical Center and Washington Hospital Center. The collaboration of agencies ensures that the school-based and the clinic-based programs also collaborate so pregnant/parenting teens receive coordinated, comprehensive care.

Staff in the Perinatal and Infant Health Bureau and the Child, Adolescent and School Health Bureau actively partners with other local youth organizations and providers to co-sponsor events and to assure that youth have access to needed services and opportunities within their communities (e.g., legal services; tutoring and academic support; entrepreneurship; mental health counseling; school health services, youth development, physical activity, socialization, mentoring and related services.) PIHIB wrote a white paper on Home Visiting.

Grants have been submitted on first time motherhood and teen pregnancy, as well as a planning

grant to the Office on Women's Health. The Coalition for Healthier Families developed an action plan to do focused studies in Wards 7&8; subcommittees are also working on issues for women and girls.CHA is also opening 3 new school based health centers.
The reorganization of Community Health Administration in FY 2008 presented some unique opportunities to examine program effectiveness, identify gaps in services and develop mechanisms to ensure programs and services were in place for CSHCN transitioning from childhood to adolescence. The Perinatal and Infant Health Bureau (PIHB) expanded its services to include the management of Newborn Hearing Screening and Newborn Metabolic Screening programs. Along with the DC Healthy Start program, these additional programs decreased resource duplication and improved identification of children 0 -- 3 years of age who are at risk for developmental delays or physical deficits. Once a problem is identified, that child is referred to Early Intervention, located in the Office of the State Superintendent of Education (OSSE). They in turn ensure that parents with a referred result on the hearing or metabolic screening are referred to the DC Healthy Start program. Once a child ages out of PIHB programs, they are referred to the CASH Bureau, as needed. The responsibility that each Bureau holds for Children and Youth with Special Health Care Needs and the coordination between the Bureaus reflects the importance of providing continuous, coordinated services from infancy to adulthood. Dr. Talwalkar meets with both Bureau Chiefs on a bi-weekly basis to discuss program and operational issues. Additionally, the PIHB and CASH program teams collaborate at least monthly to discuss and coordinate child services and programmatic issues. These two Bureaus also meet quarterly with other District agencies to identify, discuss and help resolve barriers to care for children and youth with special health care needs and their families via the CYSHCN Interagency Committee.
Each CHA employee is required to participate in cultural awareness training and requires that each of its sub grantees meet cultural awareness and competency requirements. The District meets the OMB requirements for culturally competent care based on its MCH populations. CHA includes representatives from the Latino, Asian Pacific Islander and Sub Saharan African communities to participate in Advisory Boards, focus groups and town hall meetings, and it has awarded sub grants for MCH programs. DOH provides telephone-based medical and social translation services to any person seeking information and/or services. In addition, the District supports medical translation certification programs offered by a community-based clinic.

Each of CHA's Bureaus is focused on the cultural and linguistic needs of the District's maternal and child population, including children and youth with special health care needs. A description of each of the Bureaus is presented in the Organizational Structure section that follows. The staff supports culturally and linguistically competent programs and messages for the proposed target population. One example of a culturally and linguistically competent program is the District's "I Am a Healthy DC Mom" campaign, the first in a series of targeted, culturally competent, collaborative social marketing campaigns designed to develop and enhance understanding of the protective and risk factors critical to producing healthy infants within thriving families. The goal of this program is to increase enrollment of mothers into DOH-sponsored infant mortality prevention programs (specifically African American and Latino mothers) while ensuring that women and babies from preconception to birth and beyond not only survive but thrive. This campaign will be expanded to include fathers, family members, providers and the community at large. Future campaigns will create continuity and include: I Am A Healthy DC Baby, I Am A Healthy DC Father and I Am A Healthy DC Family. The media strategy integrates cultural themes and messages through a process that integrates consumer and community stakeholder recommendations that were developed through a series of listening sessions, focus groups, one-on- one influencer interviews, an environmental scan and guidance from the collective program team (e.g. Perinatal and Infant Health staff, marketing consultants, community partners, etc.). Messages are integrated with creative images which resonate with the targeted communities. Images used launch an identity for a measureable call to action (e.g. early and continuous prenatal care, healthy eating, family harmony, etc.) The branding, "I AM A HEALTHY DC MOM" can easily be expanded to other Title V programs. Evaluation mechanisms include culturally and urban appropriate data analysis in cooperation with business marketing evaluation methods.

/2012/

Title V funded 12 grantees through FY11, focusing on maternal and child health and CYSHCN. A new Request for Applications (RFA) was created last year and in FY12 will fund Program Area A: Direct Health Care Services: Program Area B: Enabling Services: and Program Area C: Infrastructure-Building Services: As stated in their Notice of Grant Agreement, contractors must be culturally and linguistically competent. Materials that are produced by subgrantees are reviewed by CHA to ensure this.

Sub-grants awarded in 2011 included:
Mary's Center for Maternal Child Care Inc. is to implement an integrated care model in which mental health professionals collaborate with pediatricians and family physicians in the diagnosis, assessment and treatment of behavioral health services and other special health care needs of children and adolescents. These services will be offered at both of Mary's Center's Federally Qualified Health Center clinics (located in Wards 1 and 4).

Howard University's Daughters Influenced by the Intelligent Voices of Adults (DIVA) established a center to provide a coordinated comprehensive primary care center for pregnant and parenting teens and their children, which includes support resources, systems navigation help, and opportunities for health promotion and education services, referring the target population to a medical home.

Washington Hospital Center Teen Pregnancy Prevention (TAPP) Program was funded to increase the personal development and health education competencies of low-income teen mothers and fathers enrolled in public high schools in the District of Columbia in an effort to prevent subsequent teen pregnancies. TAPP addresses the social, familial, and mental health needs of teen mothers, pregnant teens and teen fathers in public high schools in DC. In 2011, DOH continued efforts to reduce the incidence of teen pregnancy in the District of Columbia by continuing to financially support the Carrera Adolescent Pregnancy Prevention Program and the Teen Alliance for Prepared Pregnancy. The Carrera program is designed to offer youth a supportive and nurturing environment, where they can learn about sexual responsibility while developing goals and aspirations for life. Simultaneously, parents are involved in the program to learn how they can assist in their child's development.

Children's Research Institute at CNMC received a grant to establish transitional case management services for at-risk children and adolescents seen in the IMPACT DC Asthma Clinic.

Advocates for Justice and Education Inc., oversee the DC Parent Information Network (DC PIN), which has identified project goals to increase access to medical homes for children with special health care needs and support seamless systems of care and transitions across service systems. The DC PIN Family Navigation Component, was designed to connect children and youth with special health care needs and their families to health care, education, and supportive services through a multi-component, community-based, family centered, and culturally competent parent consultant. Strategic Outreach was performed at various collaborative, community-based programs, childcare facilities, a foster care agency, health-related fairs, and educational institution that served a high number of special needs children. The DC PIN Care Coordination Component provides care coordination services to parents of children and youth with special health care needs. DC PIN Information and Resources Component ensures that a comprehensive information and resource collection on special health care needs and services can be used by parents, special needs providers/agencies, and community members. The DC PIN also has a Community Education Component providing parents, special needs providers and agencies, and community members with timely information on special health care needs.

National Alliance to Advance Adolescent Health (NAAAH) was funded in 2010 to conduct a comprehensive needs assessment related to health care transition, to implement and evaluate a quality improvement model to address transition barriers, to create a DC transition website, and to expand transition training. This quality improvement model for transition is being implement with 3 pediatric and 2 adult primary care sites at CNMC (2 sites), Georgetown, Howard, and GW.

A well developed transition plan will result in a child with well managed chronic conditions in an adult oriented health care system. This project is being coordinatexd with the MCHB Supported National Health Care Transiton Center.

In the future Request for Proposals (RFAs) will emphasize the need to highlight the 10 Title V priorities, as well as grantees work to address the health status indicators and the national/state performance measures.

Samples of DOH/CHA policy activities follow:
Although current DC law prohibits smoking inside school buildings, there is no prohibition against smoking on public school grounds. In an effort to assist DOH's Tobacco Control Program (TCP) to comply with the Centers for Disease Control and Prevention (CDC) Model Tobacco-Free Schools Policy to develop and gain approval of a Tobacco Free School Campus provision to be included in Bill 19-144, the "Healthy Schools Amendment Act of 2011". This provision of the bill prohibits tobacco and tobacco products "in public and public charter school buildings, grounds, parking lots, parking garages, playing fields, school buses and other vehicles, and at off-campus school-sponsored events".
In May 2010, the Council of the District of Columbia unanimously passed the Healthy Schools Act of 2010, which was then signed into law by Mayor Adrian M. Fenty. The Act focuses on improving the health, wellness, and nutrition of public and charter school students in the District of Columbia. The DOH is responsible for the management and expansion of school based health centers (SBHC). This is accomplished by: 1)Collaborating with other District government agencies, such as the Office of State Superintendent for Education (OSSE), the Office of the Deputy Mayor of Education (DME), DC Department of Mental Health (DMH), DC Public Schools (DCPS), DC Public Charter School Board (DCPCSB) and the Department of Healthcare Finance (DHCF) to establish shared objectives and to coordinate services; and 2) Partnering with community providers to build an effective SBHC network by issuing RFAs to community health care providers to operate SBHCs. Future plans are to conduct a needs assessment to determine where to place future school health centers.

On August 19,2011 District of Columbia Mayor Vincent Gray signed the "Healthy Schools Amendment Act of 2011", a legislative package which made technical changes and improvements to DC Law 18-209, the Healthy Schools Act of 2010. The Mayor simultaneously signed the "Healthy Schools Emergency Amendment Act of 2011" which enabled the "Healthy Schools Amendment Act of 2011" to become applicable at the onset of School Year 2011-2012. One of the significant policy changes affected in the "Healthy Schools Amendment Act of 2011 is the creation of tobacco free school campuses. This new policy which is the result of a two year collaborative effort spearheaded by MCH supported Child, Adolescent and School Health Bureau policy staff and CDC supported Tobacco Control Program staff.
In support of Bill No. 19-007, The Athletic Concussion Protection Act of 2011, CHA will assist with the development and implementation of an educational program to provide awareness and training on concussions and their health effects to coaches, school personnel, student athletes, and the parents or guardians of student-athletes".

The DC Immunization Program won three awards in March , 2011 at the National Immunization Conference in Washington, DC: between 2000 and 2010. Most Improved Coverage (Local); Adolescent Highest Coverage (Local); Adolescent Most Improved Coverage (Local).

In March 2011, amendments to the 2008 lead law were enacted and became effective. These amendments strengthened the 2008 lead law by expanding the reporting requirement for landlords to include any existing tenant with a pregnant woman or a child less than 6 years old in their household, and any tenant who is regularly visited by a child less than 6 years old or a pregnant woman. The amendments also require the District's Department of Consumer and Regulatory Affairs to enforce peeling paint violations of the Housing Regulations as a lead-based paint hazard violations. Other District of Columbia programs that support the 10 MCH priorities include the DC Immunization Program and the Lead and Healthy Homes Program.

The District Department of Environment announced that the agency's Lead and Healthy Housing Division has been awarded the prestigious Lead Star Award for its outstanding effort to reduce childhood lead poisoning and advance lead hazard control activities in the District of Columbia. The award was presented at the 2011 National Lead and Healthy Homes Conference in Miami, Florida.

DC Department of the Environment's (DDOE) Lead and Healthy Housing Division has become the District's focal point for lead poisoning prevention activities. The Division consists of two branches. One branch has responsibility for the District's Childhood Lead Poisoning Prevention Program which is the repository for all blood lead data for District residents under the age of six years The program also provides case management services to all children under the age of six years who have an elevated blood lead level. DDOE receives referrals from the CHA-PIHB and the Physical Fitness and Nutrition Bureau of all pregnant women whomay benefit from some direct lead poisoning prevention assistance. DDOE passes these referrals on to its sub-grantee, Lead Safe DC (the DC branch of the National Nursing Centers Consortium), which provides the client with one on one education and conducts a dust testing of their residence. If dust samples are found positive for lead, a Lead Safe DC staffer returns to and cleans the home using specialized equipment, and teaches the household how to minimize and control for lead dust.//2012//

Four goals identified for FY 2012-2016 include the following: 1) Enhance collaborative planning by obtaining higher quality data through improved monitoring of the outcomes of maternal and child health programs and activities. 2) Improve policies and procedures for the timely sharing of data with public and private sector organizations involved with the provision of maternal and child health services. 3) Consistently employ evidence-based metrics to measure program performance and outcomes. 4) Use the measured program performance and outcomes to help eliminate health disparities and to target public health services to areas of greatest need.

The attached report lists the following action steps that are designed to accomplish the four goals for FY 2012-2016: 1) Match and link the 2011 birth file with newborn metabolic and hearing screening, Medicaid, infant mortality rates, WIC and immunization data sets. 2) Link birth files with community outreach data (i.e., Healthy Start data collected by CHA and Mary's Center), lead screening data and hospital discharge data. 3) Develop and implement strategies to indentify and monitor children with birth defects. 4) Develop and implement strategies to combine the data from newborn screening, lead screening, birth defect identification, early childhood immunization data, early intervention programs and the service providers involved with these programs. //2012//

/2013/
The DC Parent Information Network (DCPIN) provides parents of special needs children with information and assistance in finding a medical home. In 2013 DCPIN plans to increase the percentage of children in a medical home through aggressive enrollment of all parents seen at DCPIN, which is being managed by Advocates for Justice and Education (AJE).

Building on the medical home transition efforts that began in 2009, CHA continued to support The National Alliance to Advance Adolescent Health (NAAAH) with its 5-site transition learning collaboratives. The sites are at CNMC-Adolescent Clinic, CNMC-Adams Morgan Clinic, Georgetown Adolescent Clinic, Howard's Family Medicine Clinic, and George Washington's Internal Medicine Clinic. In 2011, NAAAH held 2 intensive 11/2 day learning collaborative sessions with trainers Carl Cooley and Jeannie McAllister, from the National Health Care and Transition Center (NHCTC). Other efforts in 2011 included developing a transition website, and coordinating a planning committee to develop a CME transition training program in 2012. In April 2012, at Gallaudet College, the first health care transition CME program was held. It was jointly sponsored and funded by CHA,

HSCSN, and the DC Chapters of the American Academy of Pediatrics (AAP), American Academy of Family Physicians (AAFP), and American College of Physicians (ACP). The Community Health Administration with NAAAH intends to form a medical home transition quality measurement workgroup to review and recommend a set of quality performance measures that can be used to build a sustainable transition program built around the medical home model of care. A new DC transition fact sheet was prepared based on the 2009-2010 National Survey of Children with Special Health Care Needs. (see attachment) Compared to the 2005-2006 survey results, DC has improved its transition score by 10 points.

The AJE and NAAAH jointly developed a health care transition training module for the Parent Navigator Program. The first training session was held in May 2012. Additional training of the certified navigators will take place in the summer 2012, including the CNMC navigators who have been involved in the DC medical home transition learning collaborative. In addition, a parent health transition guide will be developed and youth advocates will receive training support on health care transition.

CHA supported the Howard University Hospital (HUH), Daughters Influenced by the Intelligent Voices of Adults (DIVA) program. The DIVA's goal was to increase the inter-conceptional period among teenage mothers. To accomplish this goal, the DIVA program partnered with the HUH Prenatal and Primary Care Center A + Care, Coolidge Senior High School New Heights Teen Pregnancy Prevention Program and Coolidge SHS Wellness Center. The DIVA program provided health promotion and health education and case management, and facilitated primary care services and referrals for other services as needed. During the grant period, the DIVA program successfully enrolled 59 pregnant and parenting teens in the program and reported the following: identified child care facilities for 2 participants who enrolled in GED programs; assisted 5 graduating seniors and 8 underclasswomen to identify the number of credits and volunteer hours required to successfully complete Calvin Coolidge SHS; assisted 5 graduating seniors with identifying colleges and universities offering a Single Parent Support System (Saint Paul College, Smith College, Wilson College and Endicott College); assisted 10 of the 15 participants attending Coolidge SHS with completing the Free Application for Federal Student Aid (FAFSA); assisted 2 participants with locating and securing gainful employment at ROSS, Target and restaurants located in the District of Columbia.

In 2011, CHA supported the Carrera Adolescent Teen Pregnancy Prevention Program and the Washington Hospital Center's Teen Alliance for Prepared Parenting (TAPP). The Carrera program was implemented in partnership with the Arts and Technology Public Charter School (ATA) and managed by Opportunities Industrialization Corporation (OIC). The Carrera program has 7 integrated, scientifically accurate, and age appropriate components offered daily or weekly, which work in concert to build developmental competency, identity formation and other positive youth development outcomes for participants, ultimately leading to the desire to avoid parenthood and risky sexual behaviors. The project reported the following outputs: completed a successful summer enrichment camp with 53 youth participants; enrolled 72 new program participants;12 participants received dental services; 28 participants received medical services; and100 referrals for wrap-around services were made. In addition, Washington Hospital Center's Teen Alliance for Prepared Parenting (TAPP) is a subsequent adolescent pregnancy prevention program that targets communities in the District of Columbia with a high incidence of teen pregnancy. The target population for the program includes pregnant and parenting youth and their children. Specialized support interventions are also tailored for adolescent fathers. The program is based on the premise that subsequent pregnancy prevention is more likely to occur within the context of easy access to adolescent friendly reproductive health services and accurate health information, with appropriate psycho-social supports and referrals to support services as needed. CHA will also continue funding through FY13 Mary's Center, Unity Health Care and Washington Hospital's TAPP

Program.

Title V provided funds to the District Department of the Environment (DDOE) Lead Program to find the root causes for the low compliance with requirements for second lead screening. DC law requires that all infants be screened between 6 months and 14 months of age, and again between the ages of 22 and 26 months of age. However, data for the 2007 birth cohort showed that only 53% of infants received an initial screen and only 29% received the second screen by 36 months of age. Funds are dedicated to convening 4 focus groups in areas of the city with high lead levels and low screening compliance.

The D.C. Lead and Healthy Homes Program has been named a 2012 winner of the State Program Innovation Award by the Environmental Council of the States (ECOS), the national non-profit association of state and territorial environmental agency leaders. Three programs across the nation are selected every year from among thousands of applicants nationwide. The DDOE program is a public-private partnership that identifies and assesses indoor environmental health threats to children and pregnant women. DDOE's Healthy Homes Program identifies and eliminates asthma triggers in the homes of children under the age of 18 with severe asthma, and addresses other health threats, including lead, in the homes of at-risk children under the age of 6. DDOE's Healthy Homes Program partners with the DC Department of Health, the DC Department of Human Services, the DC Department of Consumer and Regulatory Affairs, the DC Department of Housing and Community Development and the DC Housing Authority. Private-sector partners include Children's National Medical Center, Mary's Center, Healthcare Services for Children with Special Needs and Lead-Safe DC.

In addition to providing support to other public and private sector organizations to provide direct and enabling services, CHA undertook several policy development efforts. Many of the laws and regulations governing school nursing practice in the District of Columbia date as far back as 1985. Consequently, in addition to the development of new legislation, CHA is working with the professional associations to amend current laws and revise existing regulations to conform to present school nursing best practices. In FY 2012 the school nursing program is advancing the following policy changes:

1. Revising DCMR 5-2414 the Communicable Diseases Contracted by Students Regulations which contain preventive practices to help minimize the transmission of communicable diseases in schools. The preventive practices are based on the American Academy of Pediatrics recommendations, and they govern the conditions under which a child who has contracted a communicable disease can return to school.
2. In collaboration with the Board of Nursing, revising DCMR 17-61, Trained Medication Employee, to include school employees as a class of individuals who can be certified by the Department of Health to administer medication to students in accordance with requirements in SS 38-651.04. Medication administration training program, is one of the provisions of DC Law 17-107, the Student Access to Treatment Act (SATA) of 2007.
3. Amending DC Law 17-107, the Student Access to Treatment Act of 2007 to restrict the administration of medication by unlicensed school employees in emergency circumstances to asthma and anaphylaxis when a student does not have a medication treatment plan on file with the school; and to require DOH to develop, but not be responsible for implementing administration of medication training.
//2013//

An attachment is included in this section. IIIB - Agency Capacity

C. Organizational Structure

HRSA's Maternal Child Health Bureau conducted a site visit in May 2010 to discuss the organizational structure of the Title V Block Grant program overall and the organizational

structure of the two bureaus that serve children and youth with special health care needs. CHA provided the following information related to leadership, specific activities and coordination.
LaQuandra Nesbitt, MD, MPH, Senior Deputy Director coordinates the Administration's efforts to help develop an integrated community-based health delivery system, ensure access to preventive and primary health care, and foster citizen and community participation towards improving the health outcomes of women, infants, children, (including children and youth with special health care needs), and other family members in the District of Columbia. Its mission also includes the management of all administrative support functions required by the Administration. As a Board certified family medicine physician, Dr. Nesbitt provides overall technical and policy guidance on the development and implementation of Title V funded programs; works with the Title V director in making funding decisions which support Title V program goals; and identifies and obtains support from other administrations within DOH and the District government that can leverage Title V resources to expand program offerings and impact.
Anjali Talwalkar, MD, MPH serves as the Deputy Director for Policy and Programs. She develops policy and programs that support the Administration's efforts to develop an integrated communitybased
health delivery system that ensures access to preventive and primary health care.
Dr. Talwalkar administers the Title V Maternal and Child Health Services Block
Grant and provides oversight and direction to all programs within the administration that are designed to improve the health status of women, particularly those of reproductive age, and infants and children, including those with special health care needs. She provides direct oversight of the operations of the Perinatal and Infant Health Bureau and the Child, Adolescent and School Health Bureau, areas within the administration most focused on maternal and child health needs. She also supervises the staff of the Nutrition and Physical Fitness Bureau, where linkages with WIC, Breast Feeding Consultation and Supplemental Nutrition Education are established to service the maternal/child population.
Karen Watts, RN, is Bureau Chief for the Perinatal and Infant Health Bureau. This Bureau's mission is to improve health outcomes for high-risk pregnant and parenting women and to promote the health and development of their infants into early childhood, as well as the health outcomes for children with special healthcare needs, by facilitating access to coordinated primary and specialty health care and other support services in partnership with their families and community organizations. Its overarching goal is to reduce infant mortality and perinatal health disparities in the District of Columbia primarily through a home visiting approach.
Anjali Talwalkar, MD, MPH serves as the Interim Bureau Chief for the Child, Adolescent and School Health Bureau. Mr. Alvaro Simmons, M.ED, MSW, LSCW recently resigned to accept a position with the federal government. The goal of the Child, Adolescent and School Health Bureau (CASH) is to improve the health and well being of all District pre-school and school-age children and adolescents. Primarily, the bureau seeks to enhance access to preventive, dental, primary and specialty care services for all preschool and school-age children, including those with special health care needs. CASH also works in conjunction with DC Public Schools (DCPS) and the Office of the State Superintendant of Education (OSSE) to integrate special needs children into the mainstream school population. In addition, this Bureau seeks to improve age-appropriate immunizations among District residents and increase health education and outreach to District residents. This Bureau also implements a citywide asthma plan that includes data collection, public education, self-management support and clinical systems enhancement to improve asthma control for District children.
Dr. Pierre Vigilance is Director of the District of Columbia Department of Health and has served in this capacity since April 2008. As the public health agency for the Nation's Capitol, the department serves the District's population of almost 600,000 as well as those who work and spend recreational time in Washington, DC. The department has an annual budget of $268 million and more than 800 staff. In recent years the agency has promoted health and wellness through improved physical activity and nutrition projects such as community-level "Ward Walks" and the Healthy Corner Store Initiative. Under his tenure, the agency has made extensive use of data to drive the agency's activities. He has focused attention on improving data collection and analysis which has led to the publication of the District's HIV/AIDS epidemiology reports, the first city-level Preventable Causes of Death Report, the Obesity Report and the Obesity Action Plan.

Dr. Vigilance received his MD and Master of Public Health degrees from Johns Hopkins University and is residency-trained in Emergency Medicine.
Dr. Vigilance has been reelected to the Board of Directors of the National Association of County and City Health Officials (NACCHO) and will formally assume those duties in July at the Association's annual meeting in Memphis, Tennessee. As part of NACCHO's board, Dr. Vigilance provides public health leadership to address the District's health needs and offers health policy leadership on the national level. The National Association of County and City Health Officials (NACCHO) represents the nation's 2,800 local governmental health departments. These city, county, metropolitan, district, and tribal departments work each day to protect and promote health and well-being for all people in their communities.

/2012/
On January 20, 2011 Vincent Gray was sworn in as the new Mayor of the District of Columbia. He and the Department of Health are collaborating to create a Culture of Health in the District of Columbia through a city-wide push for health and wellness focusing on five core areas: Safe and Healthy Homes, Safe and Healthy Childcare, Safe and Healthy Schools, Safe and Healthy Workplaces, and Safe and Healthy Communities. "Having safe and healthy communities to live in is a basic and fundamental right to which all residents are entitled," said Mayor Gray. Crossagency collaboration is essential and a requirement to realize the mayor's "One City. One Government, One Voice" initiative.

The Mayor appointed Mohammad N. Akhter, MD, MPH as the Director of the DC Department of Health. Previously Dr. Akhter was Commissioner of Public Health for the District of Columbia from 1991-1994. Under Dr. Akhter's leadership, the DC Department of Health is focused on improving the health of all DC residents. His top priorities include implementation of healthcare reform, creating a culture of Health and Safety for all in the District of Columbia through the Live Well DC campaign, expansion of HIV services and making them available on demand, supporting the training programs for DC residents to qualify for jobs in healthcare and improving access to quality healthcare across the District.

On July 1, 2011 Richard A. Levinson, MD, DPA was appointed the Interim Senior Deputy for CHA. He joined CHA in March 2011 as the Deputy Director for Policy and Programs, as well as the new Title V Program Director. He previously was Director of the Health Management Sciences Program and Associate Professor of Health Management, at Howard University, Associate Executive Director of APHA and Director of the DC Commission of Public Health Preventive Health Services Administration.

Zaneta Brown, PhD was named Chief of the Child Adolescent and School Health Bureau in October 2010. She is responsible for the development of a state-wide adolescent and school health plan, policy development, program evaluation, and monitoring.

Mr. Bryan Cheseman was named as the interim Chief for the Office of Grants Management and Program Evaluation.

Beatriz "B.B." Otero, founder of CentroNia, a Columbia Heights multicultural learning center, was named the District's Deputy Mayor for Health and Human Services on Friday, February 4, 2011.
//2012//

/2013/
The CHA is one of several administrations in the health department. No major changes in the Department of Health's organizational structure were made in the past year. In FY 2011 the DOH operated with a budget of $271.6 million and 774 staff positions. CHA's approved budget was $89.9 million, the majority of which is federal grants, and had position authority for 211 FTEs. CHA is comprised of 6 bureaus: Nutrition and Physical Fitness Bureau; Perinatal and Infant Health Bureau; Child, Adolescent and School Health Bureau, Cancer and Chronic Disease Bureau; Pharmaceutical Procurement and Distribution

Bureau; and the Primary Care Bureau. CHA also has an office for grants monitoring and program evaluation. However, in June 2012, the new CHA leadership convened an all-day staff retreat for Senior Managers and Program Directors. One of the primary goals of this retreat was to initiate staff input and information gathering regarding the planned CHA realignment plan. The realignment is expected to be implemented by October 1, 2012. The realignment aims to address the need for enhanced coordination and integration of departments; focused grants, priority setting, improved operations effectiveness and establish a directed epidemiology, statistical analysis unit within CHA.

Significant changes in CHA leadership have occurred since the previous report. On December 10, 2011 Farouk A. Hosein was named as CHA Deputy Director of Operations and as the interim director for the Office of Grants Management. He has had a long career in DC government with previous duties as Director of Operations for the Alcohol, Beverage Regulation Administration, and Chief Contracting Officer for the DC Child and Family Services Administration.

In January 2012, Samia Altaf, MD, MPH, was appointed Senior Deputy Director for Community Health Administration, replacing Richard Levinson, MD, who was appointed Senior Deputy Director for Medical Affairs in December 2011. Dr. Altaf is a primary care and public health physician licensed by DC Board of Medicine and certified by the American Board of Public Health and Preventive Medicine. Dr. Altaf has worked for the District in the field of Public Health and for the World Health Organization in several international settings. She has also worked in the California county health system managing STD and TB clinics, and as Medical Director and Chief of Quality Assurance for the DC Medical Assistance Administration and the DC HIV/AIDS Administration. Most recently Dr. Altaf served as the Chief of Health Services for the DC Department of Youth Rehabilitation Services,

In May 2012, Jeanne J. Taylor, Ph.D., was hired as Deputy Director for Policy and Planning for the CHA. Prior to joining the DOH, she held executive positions at several FQHCs in Boston, MA, and Los Angeles, CA. She has also served as the Assistant Dean of Ambulatory Care for at the University of Chicago, Pritzker School of Medicine and Medical Center. Dr. Taylor has also served as Lead Administrator of a LA County Public Health Community Center. In both her professional and volunteer work, she has focused her efforts on primary prevention programs such as Healthy Start.

Charlissa Quick, RN, MSA, was appointed Interim Bureau Chief of the Child, Adolescent and School Health Bureau and Kathleen Rogers was appointed Interim Bureau Chief Cancer and Chronic Disease Bureau respectively in 2012. Dr. Farah Naz, joined CHA in July, 2012, as Oral Health advisor. Dr. Naz is a Public Health Dentist with over eight years of International experience (working with the World Health Organization) in the practice of General and Pediatric Dentistry. She has also worked in Oral Health Policy, Planning and Evaluation; and in improving quality, and monitoring and evaluation of Oral Health Service delivery for HIV/AIDS affected, incarcerated, and other marginalized population subgroups in the US and at the national level.

The new leadership is well prepared to implement the DC Healthcare performance mandate to address how to best organize CHA to serve our intended populations. //2013//

An attachment is included in this section. IIIC - Organizational Structure

D. Other MCH Capacity

The Full Time Equivalent (FTEs) positions supported by Title V funds for 2011 include: Administration (the Office of the Senior Deputy Director includes Grants Management and Program Evaluation, Finance and Data Analysis) -- 38.75; Perinatal and Infant Health Bureau -

10.75; CASH Bureau - 12. Additional staff are in Program Support Services. The total number of FTEs is 61.5. More than 18 parents consistently participate in DOH/CHA-led committees and advisory boards. Parents also participate on sub grantee advisory boards and committees, such as the National Alliance to Advance Adolescent Health, and parents strongly engage in focus groups and Town Hall meetings. CHA is currently seeking candidates for the CASH Bureau Chief position recently vacated by Alvaro Simmons. Other vacant positions to be filled include a nutritionist, lactation coordinator and epidemiologist.

The additional administrative resources available to the Title V Program include the Office of the Deputy Director for Operations, headed by Sandra Robinson, which provides administrative support to all CHA programs and activities, including but not limited to: Budget and financial management; grant monitoring and program evaluation; personnel; performance management, labor relations; procurement; facilities management; risk management; and fleet coordination. While she directly supervises the staff of the Office of Program Support and the Office of Grant Monitoring and Program Evaluation, for the purposes of Title V, a dotted line relationship exists between the managers of these offices and Dr. Talwalkar, in her capacity as Title V Director.

Program Support Office - This office coordinates the following activities for the Title V program: budget preparation and submission, forecast and spending plan development and monitoring, budget variance analysis, budget change requests, and the general oversight of budgetary information and reports to ensure appropriate allocation and earmark requirements are met for Title V resources. The unit also provides accounting operations services including cash management, fund certification, revenue and expenditures tracking and reporting, intra-district transactions, accounts payable certifications and all monthly, quarterly and annual closing activities and annual financial reporting.

Office of Grants Monitoring and Program Evaluation - Charles Nichols, MPP, Chief

This office provides fiscal and administrative monitoring of District and federally appropriated funds in the form of grants and sub-grants to local non-profit and not-for-profit providers. Fiscal monitoring includes ensuring that grant funds are expended in accordance with Federal and local grant regulations; conducting site visits; providing technical assistance to grantees and subgrantees;

and providing ongoing analysis of grant spending to program counterparts. It also provides support for the Administration by designing data collection systems and providing strategic program planning, program evaluation and consultation services. This includes the provision of reliable data on women, children (including those with special health care needs) and families for use in program planning and development.

Finance - DC DOH finance staff has extensive experience in public financing and complies with accounting and fiscal management standards of GAAP and OMB Circular A-133. To meet all grant financing and OMB tracking and reporting requirements, the DC's Office of the City Administrator (OCA) and Office of the Chief Financial Officer (OCFO) have distributed guidance to District agencies on how to separately track and identify all federal funds made to the District. The guidance states that agencies will be held accountable for ensuring full compliance with all Recovery Act requirements. The Office of Budget and Planning (OBP) under the OCFO has modified the District's accounting system of accounting and reporting (SOAR), as well as the District's Grants Management System (GRAMS). Each department within District Government is responsible for tracking and reporting all federal funds in collaboration with the Office of the City Administrator. All new grants to a city agency is reported to this office by sharing the Notice of Grant Award (NOGA), once reported tracking and reporting requirements are established to ensure compliance with OMB guidance for tracking and reporting of federal funds. The District's guidance calls for the assignment of a unique four digit code (the fund detail) in SOAR for Recovery Act funds, which will facilitate separate tracking. Individual fund details are labeled from specific sources. These fund details help to ensure accurate counts of all line item expenditures. The overall operating budget for the Health Department for fiscal year 2011 is $279,717,936. The operating budget for CHA is $36,381,345.

Several additional resources exist in the District to promote and enhance maternal and child health. These are funded by other sources that support the goals and objectives of the Title V MCH grant. They include: HRSA funded Oral Health Programs; local funding for the Healthy Babies home visitation project; DDOE funding of case management services for children at-risk

for lead poisoning as well as environmental assessments of residences; USDA programs such as WIC and SNAP-ED; Early Intervention and special education services provided by the Office of the State Superintendent of Education, DC Public Schools and the Department of Mental Health; teen pregnancy prevention programs funded by the Department of Human Services; and three new school-based health centers plus two wellness promotion programs funded through the Master Tobacco Settlement funds.

/2012/
Collaborators in nutrition and physical fitness have been greatly aided by local legislation that has supported healthy eating and active living initiatives through our educational system. The DC Healthy Schools Act of 2010 enhanced the nutrient quality of school meals by requiring schools to meet the USDA Healthier US School Challenge program at the Gold Award level for vegetables, fruits, whole grain and milk. It has also imposed staggered requirements to improve the level and quality of physical education in the schools, so that by school year 2014-25, the schools must offer an average of 75 minutes per week of health education, and to work with the State Board of Education to consider ways of expanding physical education in high schools. This legislation has inspired the Office of State Superintendent (OSSE) Early Childhood Education division to issue proposed regulations requiring all licensed Child Care facilities to provide more nutritious meals and at least two hours of activity daily, with one being structured physical activity. DOH used Preventive Health Services Block funds to develop A Better Children's Diet, which is a training guide program for providers. Both center and family day care home providers have been participating in the training along with the advisory committee. There will be two guides one for healthy eating and one for physical activity, accompanied by a DVD. Additionally, materials have been secured in Spanish, along with implementing several trainings for Spanish-speaking providers that included a Spanish-only session as well as English trainings where direct translation services were provided.

The DC Department of the Environment Lead and Healthy Housing Division, is responsible for: promoting lead screening of children; home health and safety education; providing case management services to the families of lead poisoned children; educating contractors and property owners on lead-safe work practices; accrediting and certifying training providers and contractors; issuing lead abatement permits, and eliminating lead-based paint hazards throughout the District. In addition, DDOE and its Lead and Healthy Housing Division have been hosting quarterly interagency meetings on lead, to ensure all agencies are up to speed on developments and ensure coordination is occurring with respect to each agency's lead-related responsibilities.

The Sexually Transmitted Infection Community Coalition (STICC), in partnership with OSSE and DCPS, held its second annual youth STICC Summit in June 2011. A group of DC youth worked together to bring awareness to reproductive health concerns of youth in DC and the surrounding areas. The Mayor released in June 2011 the Annual Report showing Progress on Addressing HIV/AIDS, STDs, Hepatitis, and TB in the district. DC continues to increase HIV testing, with nearly triple the number from 2006. Since 2007, DOH has doubled the number of residents receiving free HIV medications: distributed 4 million free condoms in 2010; and reached 5,000 young people with free voluntary STD testing. //2012//

/2013/
Advocates for Justice and Education (AJE) and its DC Parent Information Network (DCPIN) was named by HRSA as the Family to Family Health Information Center (F2F HIC). In this capacity staff provides, free of charge, support to families of children and young adults with disabilities and special health care needs. In partnership with Mary's Center, a FQHC, AJE provides families and providers face to face and online training on topics related to health care. Their main purpose is to help families navigate through the DC health system, connect families to resources in their communities, and help families develop skills to work cooperatively and effectively in decision making and planning on health related issues.

With support from SAMHSA, the District developed the Fetal Alcohol Spectrum Disorder (FASD) State Plan, which was submitted to the FASD Center for Excellence on October 30, 2011. In July 2011 the District of Columbia was recognized as an approved resource for distribution of information on Fetal Alcohol Spectrum Disorders by National Association of FASD State Coordinators. Staffs of community based organizations providing maternal and child health-related services are being trained on the dangers of drinking alcohol. Based on reports of conflicting advice and practices on the part of local primary care providers, the Perinatal and Infant Health burau (PIHB) plans to work with the DC Medical Society and the local chapter of ACOG to provide guidance on the use of alcohol during pregnancy.

//2013//

An attachment is included in this section. IIID - Other MCH Capacity

E. State Agency Coordination

CHA continues its 2010 efforts for intra and interagency collaboration including agency representatives, parents, caregivers, youth and advocates. Sister Administrations in DOH such as HIV, AIDS, Hepatitis, Sexually Transmitted Disease, and Tuberculosis Administration (HAHSTA) and Addiction Prevention and Recovery Administration (APRA), coordinate activities with DC Public Schools, Office of the State Superintendent of Education, Department of Mental Health, Department of Human Services, District Department of Environment, Department of Corrections, Department of Employment Services and Department of Health Care Finance to ensure screening and identification of at-risk families for acute and chronic health/medical, educational, and environmental factors. Collaborative programs are around the following issues: prenatal care and home visitation, Sickle Cell, HIV/AIDs and sexually transmitted diseases, hearing and metabolic screenings and counseling; tobacco cessation, mental health and substance abuse treatment, lead testing and environmental assessment; and nutrition and physical fitness. Programs conduct outreach to residents in homes, shelters, correction facilities, clinics and hospitals. CHA also collaborates with DC City Council to develop and promote policies to ensure access to care, such as allowing students access to asthma treatment in school and supporting the DC Medical Homes project through the DC Primary Care Association.

The other agencies and organizations that collaborate with CHA in supporting and/or providing services to meet the Title V objectives include the sub grantees: Children's National Medical Center, Georgetown University Hospital; George Washington Medical Center, Washington Hospital Center; Howard University Medical Center; Advocates for Justice; National Alliance to Advance Adolescent Health; United Health Care/Breathe-DC; Mary's Center; HSCSN Inc, Fitness for Health, and Associates for Renewal in Education Inc.

Maternal and child health programs, such as Healthy Start and WIC, coordinate with the Office of the State Superintendent of Education (OSSE) efforts around early childhood nutrition and the Adult and Child Food Program. OSSE also requires that Early Care and Education Centers meet standards around healthy foods at meals and snacks. A CHA-funded program provides training to early childcare providers on the requirements and technical assistance around implementation of the standards.

There are six collaboratives, including Healthy Families, National Alliance to Advance Adolescent Health, Thriving Communities, that provide parenting education and workshops, with the goal being strengthening families, in order that the family unit remains intact but functions in a more healthful manner. DOH Health Educators provide health education workshops to the collaborative on reproductive and perinatal education topics including prenatal care, nutrition, FASD, SIDS, and healthy weight.

Agency coordination efforts also include the efforts of advisory boards and focus groups. The Children with Special Healthcare Needs Advisory Board (CSHCN Advisory Board) serves a key role in identifying and addressing the needs of children with special needs. The CSHCN Board invites parents of special needs children to become involved in their organization to learn more

about programs and resources available to them and their children and how to navigate the access points. Recently, the CSHCN Board conducted a training program for families and parents related to Title V.
An Interagency Committee on Children and Youth with Special Health Care Needs was established this grant year and is comprised of representatives within the DC government that serve children with special needs, including CHA Bureaus, Child and Family Services, Department of Mental Health, District Department of the Environment, DC Public Schools, and Department of Health Care Financing. The initial discussions of the Committee included identification of agencies involved with children with special needs, how children are identified, and the need for an environmental scan. The tasks for the upcoming year include creation of a charter, defining its purpose, membership, objectives, activities, etc. Committee will meet quarterly.
The Advisory Committee for Perinatal, Infant and Interconceptional Health and Development, chartered in 2008, focuses on PIHB strategies to decrease infant mortality and product healthy DC moms and babies. In the new grant year the Advisory Board will re-evaluate its charter and review the infant mortality action plan to identify new strategies and initiatives. The Advisory Board identifies and compiles best practices and provides recommendations to CHA based on existing data regarding infant mortality and perinatal outcome disparities. Its evaluation process includes, incorporating systemic assessment of psycho-social and behavioral risk and protective factors as part of perinatal, infant and prenatal interconceptual practice.
The Title V related focus groups provide an opportunity for the community of residents, providers and advocates to respond to specific issues related to policy, access to care, Title V resources are used to sponsor two parent advocates to participate in each AMCHP Conference and one parent to serve as an AMCHP delegate. Parent participants are referred by the Advisory Board and selected by the Title V Director.
Each Title V Director actively participates in board meetings, board development and training. In FY 2009 DOH applied to HRSA, on behalf of the Board, to obtain technical assistance to conduct an organizational assessment. (A copy of that assessment can be made available upon request). Additionally, the CHSCN Advisory Board has been instrumental in assisting CHA in identifying parents to participate in stakeholders meetings, focus groups and other activities where the input of parents and/or caregivers and guardians can be obtained on MCH issues and concerns, such as access to care, resources, health insurance, and/or education.
DOH's Asthma Program has partnered with asthma programs in Maryland and Virginia to form a National Capital Region Asthma Partnership to address the burden of asthma across state lines. The first Regional Conference was held in May 2010. Data analysts from across the region have collaborated to analyze regional-level asthma morbidity data. Findings will be used to inform.

/2012/
Internal and external partnerships allow CHA to work effectively to accomplish its Title V goals. The CYSHCN interagency committee membership also participated in the Citywide Pediatric Forum, an internal and external collaboration which aims to lead, support and collaborate on various topics concerning a child's life. DC DOH and CNMC and DC Primary Care Association (DCPCA) spearheaded efforts to address disparities among all youth including children with special health care needs. The agencies met in FY2010 and FY2011 to identify objectives and goals for a Citywide Child/Youth Action Plan.

The CSHCN Advisory Board's mission is to provide advice and recommendations from a community based perspective to CHA on planning and implementing services in the District of Columbia on family centered, community based, coordinated care for these children and youth. They also work to promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for CYSHCN. Goals to fulfill the board's mission include: 1. Represent community needs and expectations, 2. Engage proactively with the Community Health Administration, and 3. Operate effectively as an advisory board. To accomplish these goals the Board will strive to maintain an appropriate representation of community members to include providers, consumers, and cultural groups; obtain timely community input related to needs and desires for satisfaction with services for CYSHCN and

effectively communicate this information to the CHA; and assist in educating the community of CHA's initiatives, plans and services. The board will plan to communicate regularly and clearly with CHA, to understand current and future initiatives in order to provide timely advice and recommendations; and ensure that to provide ongoing communication between leadership and key staff of CHA and the Board. Current membership consists of parents, advocates, providers and DOH employees.

PIHB Advisory Committee on Perinatal, Infant and Interconceptional Health and Development met during the year to update the Infant Mortality Action Plan.

The Department of Health Care Financing (DHCF), formerly the Medical Assistance Administration, continues its mission to serve the uninsured and under insured residents through management and oversight of the Medicaid and Alliance programs. DHCF collaborated with CHA to develop the Global Authorization Form to allow providers for additional screenings like those for substance abuse and depression. DHCF also provided additional funding of DC Linkage and Tracking System (DCLTS) to identity potential children with developmental delay.

The Lead Poisoning Elimination and Healthy Homes Advisory Committee is organized for the purpose of providing advice and guidance to the administrators of lead poisoning prevention and healthy housing programs concerning any issues that impact upon these programs. Membership consists of people involved in lead poisoning prevention and healthy housing in the District of Columbia, including health care providers, environmental health advocates, community health educators, and other lead poisoning and healthy housing stakeholders.

The DC Asthma Partnership (DCAP) engages community partners in a coalition to work on policy issues, to reduce repetitive efforts and form one voice in policy and advocacy issues. DCAP is the primary tool in the district for addressing and improving asthma management and prevention. DCAP partners work together to implement the Asthma Strategic Plan's key strategies with the ultimate goal of improving the health of District residents. In 2010 DCAP joined with the Maryland and Virginia Asthma Control Programs to form the National Capital Region Asthma Partnership to work on issues across regional borders. A regional fact sheet was developed to illustrate the burden of asthma in District of Columbia, Maryland and Virginia. The DCAP also has a website and listserv informing partners of the latest trends in asthma. Currently DCAP is working with the DOH to launch a citywide back to school social media campaign to raise awareness of asthma self-management emphasizing the importance of having a completed asthma action plan on file with school. This will ensure that children with asthma are able to carry and self-administer their asthma or anaphylaxis medication.
In August DCAP released the new and improved DCAP Website.
http://ww.dcasthmapartnership.org. A newer version of the asthma action plan was also released.
//2012//

/2013/
CHA works with a vast array of partners within the health department, across other government agencies, with publically supported private sector entities, professional associations, and advocacy groups. CHA continues its partnership with the lead program in the District Department of the Environment (DDOE). Through an intra-district transfer of funds to the lead program, staff members are focusing on increasing compliance with lead screening requirements for children less than 2 years of age.

The DC Home Visiting State Plan was developed with funds from the Affordable Care Act (ACA) Maternal, Infant, and Early Childhood Home Visiting Programs. The grant was awarded in FY 2011 and involves a number of partners. Public partners, in addition to DOH, are the Department of Mental Health, Child and Family Services Agency and the Office of the State Superintendent of Education. Prior to funds being made available, the DC Home Visiting Council started the process of developing home visiting policies and procedures and setting standards for the District, with the aim of achieving quality and

improved child and family outcomes from investing in home visiting programs. As a result, the DC Home Visiting Program will work closely with the Council to continue this initiative. A central intake system will be established to identify which home visiting service agencies may be providing services to the same clients in order to improve the allocation of resources and utilization of the services. A needs assessment indicated that a home visiting program would be most beneficial to low-income, pregnant women, as well as parents and caregivers of children birth through 5 years residing in Wards 5, 7 and 8. Based upon a review of evidence-based home visiting programs, Parents as Teachers (PAT) and the Home Instruction Program for Preschool Youngsters (HIPPY) were selected. An RFA was issued and sub-grants were recently awarded to Mary's Center, an FQHC, to implement PAT and to The Family Place to implement HIPPY.

CHA manages another multi-year grant that calls for the active participation of other government departments and agencies. This grant known is known as Linking Actions for Unmet Needs in Children's Health (Project LAUNCH), is funded by SAMHSA. Project LAUNCH is directed toward the formation of partnerships across the Department of Mental Health, DCPS, and DOH to train select elementary school and child development staffs in screening children from birth to eight years, identify those who could benefit from mental health or early intervention services, and make and follow up on referrals. In addition a parent education component was implemented. The overarching goal is to promote wellness of young children from birth to eight. By the conclusion of FY 2011, 835 children had been screened using the T-CRS in 8 child development centers and 5 schools in Wards 7 and 8 of the District of Columbia. The PMHCS was used to identify children at risk and to implement the Healthy Futures program in 24 child development centers. The project was considerably delayed because of the time involved in finalizing MOUs with these agencies.

DOH has had an agreement with the Department of Mental Health since 2001 to provide mental health services to Healthy Start clients who screen positive for depression on the DES-D. The agreement funds two licensed clinical social workers to receive, assess, diagnose, treat, and follow clients. Performance reports for 2011 indicate that although 100% of referrals to mental health services were completed within 3 weeks, slightly less than 1/3 of clients were ever screened for depression.

On May 31, 2012 Mayor Gray announced that the District has been awarded more than $2.9 million from U.S. Department of Housing and Urban Development to conduct a wide range of activities to protect children and families from potentially dangerous lead-based paint and other home and safety hazards. The funds will be administered through the D.C. Department of Housing and Community Development's Lead Safe Washington Program (LSW), which provides grants for the identification and control of lead-based paint hazards to reduce the health hazards to individuals of all ages, and, in particular, to children younger than 6 years of age.

Each DC public school has at least one full-time RN on site. The DOH contracts with Children's National Medical Center Children's Health Services for staffing. As of June 15, 2012, there were a total of 158 school nurses (141 full-time, 17 part time, 1 vacant). CASH provides oversight to the contract. DC public charter schools may have a nurse upon request. Described in another section of this report, 5 school based health centers are in operation. School nurses and health center staff assist with group health and sexuality education in addition to individual counseling. Through Tobacco Settlement Funds, 16 primary care site renovations have been completed or are underway.

The CHA Tobacco Program analyzed the calls to the Tobacco Quit Line (January 2010 -- March 2012) and found that 7,148 callers registered, enrolled in counseling (IR = Intervention Requested) or were sent materials (MO = Materials Only). Of these 3,854 tobacco users were female and 3,287 were male. Of the female callers 50 were pregnant. A

7-month follow-up evaluation was conducted for all registrants. Due to the low number of registered pregnant callers, a specific analysis of that group could not be conducted. If funding allows in the next year, emphasis will be placed on increasing educational efforts to women, especially pregnant women.

In June 2011, the Sexually Transmitted Infections Coordination Council (STICC) organized a youth conference which was held at a DC high school. The summit, called "Youth STICC'in 2-gether", brought together youth and adults working on issues around reproductive health to create a unified message and determine policy and programming needs in the District. Approximately 40 young people attended the conference. STD and HIV screening was offered by 10 STICC member organizations during a World AIDS Day activities.

The Bureau of STD Control in the HIV/AIDS, Hepatitis, STD, and TB Administration (HAHSTA), maintains the School-based STD Screening Project (SBSP) which was located in 22 senior high schools during the 2010/2011 academic year with the goal of addressing three major issues: 1) bypass the well documented barriers to adolescents obtaining quality healthcare, 2) supplement the quality of the comprehensive sexual education occurring within DC public schools, and 3) identify and treat new Chlamydia and Gonorrhea cases among one of the District's most vulnerable subpopulations, ultimately reducing the high number of cases of gonorrhea and chlamydia occurring among 14-19 year olds. The bureau provided information and voluntary, confidential urine based screening for high school students.

The Oral Health Work group from the Citywide Pediatric Forum became a 501c(3) nonprofit organization, the DC Pediatric Oral Health Coalition. The coalition is addressing the following isuses:1) the availability of dentists treating Medicaid children and medical reimbursement rates; 2) collaborative relationships between dentists and pediatricians; 3) the burden of paper work associated with Medicaid; 4) alternative dental providers; 5) changes in scope of practice to allow fluoride varnish applications by licensed non-dental health care providers; and 6) other public health interventions impacting on oral health such as the enforcement of annual dental visits for students entering DC Public Schools at the beginning of the school year.

Working with the CHA, Perinatal and Infant Health Bureau (PIHB), the Perinatal Coordinator at HAHSTA participated in a variety of local events to promote HIV testing and regular condom use in DC. The coordinator worked collaboratively with PIHB by participating on the Advisory Committee on Perinatal, Infant and Interconceptional Health and Development. The coordinator and other prevention colleagues have also been able to provide technical assistance regarding rapid HIV testing as necessary. No cases of perinatal transmission were reported in 2010.

The Title V Maternal and Child Health priorities are among the health and wellbeing concerns that have been identified by the Child and Family Services Agency. CFSA provides services to the same high risk populations which are the focus of several Title V supported efforts.

The Department of Health Care Finance (DHCF), the single state agency responsible for the administration of the Medicaid program, provides funding annually to CHA to administer the DC Linkage and Tracking System (DCLTS). Within DHCF's Division of Children's Health Services, the DCLTS seeks to provide data to improve the health outcomes for children between the ages of 0-to-3 who are at risk for developmental delays and disabilities or who exhibit signs or symptoms of developmental delays through early identification. The DCLTS provides a tracking mechanism to identify such children and make linkages with appropriate services for these children.

//2013//

An attachment is included in this section. IIIE - State Agency Coordination

F. Health Systems Capacity Indicators

/2013/

Health Systems Capacity Indicator 01: The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.

To respond to this section Title V staff decided to examine HSC 01 the hospitalization of young children with asthma, an ambulatory-sensitive condition. In conjunction with the 2010 needs assessment, the reduction of asthma morbidity was identified as and remains one of the10 priorities. In order to continue to reduce the number of children hospitalized for asthma, the Asthma Control Program is promoting the reorganization of the 77-member DC Asthma Partnership (DCAP) to encourage more effective and efficient collaboration among community-based organizations. The asthma partnership is comprised of Government, CBO's and consumers have been actively meeting regularly with DHCF MCO's and CBO's to revise and recommend reimbursement procedures for certified asthma educators. One of two primary focus areas was establishing an active and cohesive parent group that informed advisory groups of the needs of parents related to improving management of their child's asthma. The school health program supports asthma self-management by students. Students are allowed to bring to school and use their inhalers when they have a current asthma plan on file with the school nurse. School nurses as well as the staffs of the school-based health centers receive periodic in-service training on asthma management with an emphasis on providing information and education to students and staff.

The District of Columbia Asthma Control Program, DC Control Asthma Now (DCCAN) currently uses the most recent BRFSS data to monitor trend in asthma prevalence for children. The dataset is used to set targets for asthma prevalence in specific populations, including children 0-4 yrs, 5-9yrs 10-17. The DCCAN also utilizes hospital discharge and emergency department to monitor trends in asthma management. In 2009, the most recent year available, the emergency department visit rate was 374.0/10,000 for children age 0-17, while the hospital discharge rate for that same group was 44.5/10,000. Highlighted in other sections of this report, CHA management recognizes the need to strengthen surveillance both within the health department, with other DC government agencies, and with the DC Hospital Association.

Social marketing initiatives to promote improved self-management have been implemented in three phases to date. The DCAP website was revised to be more user-friendly and include more useful information. Facebook and Twitter sites have been launched to provide a forum for exchange among people with asthma, caregivers, health care providers and community members. The DCAP administrative manager has also used these venues to communicate key information on asthma care. This initiative is supported by the Preventive Health and Health Services Block Grant.

To further promote positive and active healthy lifestyle experiences for children with asthma, Breathe DC will conduct a series of summer day and overnight camps in summer 2012 for children aged 8-12 years. The children will learn about asthma self-management in an interactive and fun setting. Parents/caregivers will also participate in asthma management health education sessions, and this camp is supported by Title V funds.

The pediatric asthma program Improving Pediatric Asthma Care in the District of Columbia (IMPACT DC) piloted and implemented a case management system targeting transitional services to at least 400 patients to demonstrate measurable improvements in outcomes.

The program exceeded its target as indicated by the case management services provided to a cumulative total of 677 families in the IMPACT DC Asthma Clinic in the first year of the grant. They fully integrated the case management protocols into the Clinic's workflow after an early pilot, and then provided services to all families seen in the IMPACT DC Asthma Clinic during the remainder of the grant year. The case management services provided to every family during their clinic visit include education around the chronic nature of asthma and emphasis on the importance of ongoing follow-up asthma care in the primary medical home.

All families also receive follow-up case management services including booster calls that reinforced key messages and explored any barriers to follow-up that may have arisen. One of the case managers' primary goals was to confirm the follow-up plan with the family. The program database indicated that the case managers were able to reach 82% of families for a booster call. Of those families reached, the case managers confirmed that 75% of families had scheduled or already attended their primary care follow-up visit after receiving coaching from the case managers. A subset of families received more intensive assistance from the case managers in the form of direct facilitation of appointment scheduling and the provision of additional reminder calls.

In addition to booster calls, families received services such as referrals to specialty clinics and/or community resources, tailored landlord letters to address environmental triggers in the home, or assistance with insurance and/or transportation issues. The case managers facilitated referrals to various external community resources for 31% of families served to-date. For assistance with housing issues, the case managers wrote letters to landlords regarding household exposures and housing codes for 20% of families during the first year of grant funding. Finally, of the 677 families who received case management services during the first grant year, 20% received assistance with referrals to the Allergy Clinic, and 5% to the Pulmonary Medicine Clinic. Collectively, these referrals reflect the effort of the case managers to provide concrete, comprehensive services to every family seen in the IMPACT DC Asthma Clinic. This was also supported by Title V funds.
//2013//

An attachment is included in this section. IIIF - Health Systems Capacity Indicators

IV. Priorities, Performance and Program Activities

A. Background and Overview

The Community Health Administration (CHA) at the DC Department of Health (DOH) continues its oversight and management responsibilities for the Title V Maternal and Child Health Block grant. Its responsibilities include
but are not limited to: promoting the goals and objectives of the Title V grant, budget management, development and oversight of sub grants to community based organizations providing programs to support Title V objectives, leading and/or participating in inter- and intraagency collaborative efforts, periodically reporting the status of activities and accomplishment of
objectives, and attending HRSA meetings.

The mission of the Community Health Administration is to improve health outcomes for targeted populations by promoting coordination within the health care system, by enhancing access to prevention, medical care and support services, and by fostering public participation in the design and implementation of programs for DC women, infants, children and adolescents (including children with special health care needs) and other family members.

DOH's strategic plans include the adapting a model for better understanding the development of disease and the promotion of health. Neal Halfon, MD, MPH, Director, UCLA Center for Healthier Children, Families, and Communities, and Professor of Pediatrics, Health Sciences and Public Policy designed the Life Course Health Development (LCHD) as a model approach to build on longitudinal connections and development periods models by specifying the biological and behavioral mechanisms that determine health priorities. Dr. Halfon and others have suggested that the health development process is determined not just by the cumulative impact of risk and protective factors but by the timing of exposures. Tthere are optimal times for
positive interventions or -- more pointedly -- missed opportunities when these interventions do not occur during the important developmental periods. Likewise, there are periods of heightened vulnerability, during which negative exposures can be especially damaging.

DOH supports the LCHD model which provides an opportunity to transform children's health at the "early part of the lifespan. In many cases, promoting optimal lifelong health may be best achieved through means other than "traditional" health care interventions." The LCHD model will guide CHA in evaluating
current programs, identify gaps in services and prioritize life-long prevention interventions. This process will require review of current and availability of meaningful health insurance coverage for all children plus significant investments in community-based prevention, health promotion, developmental support services, and information systems to provide the health development scaffolding that children need to thrive. Adoption of this strategy would help to
reverse the alarming trend of health disparities for the youngest generation and focus on early, high-return investment on children's health and subsequently, their future. Each of CHA's Bureaus leadership guide staff and grantees in meeting the objectives of the Bureau as related to the Title V grant.

Nutrition and Physical Fitness Bureau: to provide food, health and nutrition assessments and interventions, education and referral services to District families, infants, children, and seniors to affect dietary habits, foster physical activity, decrease overweight and obesity rates and thus improve health outcomes of District residents.

The Perinatal and Infant Health Bureau: to reduce perinatal outcome disparities
(including infant mortality, very low birth weight, and preterm births and to improve the preconception/interconception health of women and infants residing in the District of Columbia. Its activities include: the DC Healthy Start Project; DC Linkage and Tracking System,
Epilepsy Awareness Project, Fetal Alcohol Awareness Syndrome Prevention Program.

Cancer and Chronic Disease Prevention Bureau: to reduce the incidences, morbidly
and mortality of cancer and chronic disease in the District.

Primary Care Bureau mission is to increase access to quality primary health care services within an integrated health care delivery system. The Primary Care Bureau oversees the development of three new school based health care clinics.

Pharmaceutical Procurement and Distribution Bureau: organized in FY2010 under CHA. This Bureau maintains a timely and efficient drug delivery rate of greater than 99%, and assures that the Department of Health continues to maintain access to drug discount programs that will allow as many District residents as possible, access to life saving medications.
In the upcoming grant year CHA will focus on and consider the federal opportunities presented in "The Patient Protection and Affordable Care Act Maternal and Child Health Related Highlights". These Federal funding
opportunities include: Prevention and Public Health; Childhood Obesity Demonstration Project; Community Transformation Grants, Maternal, Infant, and Early Childhood Home Visiting Programs.
CHA will also work with DCPS and OSSE to ensure that they conduct youth surveys related to the DC Youth Behavioral Risk Survey (YRBS). The detailed description of programs provided by each Bureau is attached in section Agency Capacity.

/2012/
The Community Health Administration (CHA) continues to provide oversight and management responsibilities for the Title V Maternal and Child Health Block grant. The CHA mission has not changed: to improve health outcomes for targeted populations by promoting coordination within the health care system, by enhancing access to prevention, medical care and support services, and by fostering public participation in the designed implementation of programs for District of Columbia women, infants, children and adolescents (including children with special health care needs) and other family members.

CHA responsibilities remain the same: promoting the goals and objectives of the Title V grant, budget management, development and oversight of sub grants to community based organizations providing programs to support Title V objectives, leading and/or participating in inter- and intra- agency collaborative efforts, periodically reporting the status of activities and accomplishment of objectives, and attending HRSA meetings.

In order to better understand the actions of our community partners as it pertains to our state priorities, an MCH scan was developed and distributed widely. The results were used to populate the next section which details the state priorities. //2012//
/2013/
CHA continues to provide oversight for and manage the Title V Maternal and Child Health Block grant. CHA continues to strengthen collaborative partnerships with other DOH administrations and other DC government agencies. CHA has also put special emphasis on developing stronger relationships with the CSHCN advisory board, especially in developing priorities and outreach to the community.
//2013//

An attachment is included in this section. IVA - Background and Overview

B. State Priorities
The District's priorities for 2010-2015:

1. Decrease infant mortality. (ES)
The PIHB will continue its oversight of the ongoing home visitation and case management services to women and their babies in Wards 5, 6, 7 and 8, Mary's Center and Washington Hospital Center in Ward 5. PIHB social marketing campaign will expand to include outreach to pregnant women and mothers on various topics such as screening, testing, periodic primary care visits, breast feeding, nutrition, and growth and development. CASH will collaborate with the DC Public Schools and DC Public Charter Schools to provide health and sexuality education

programs and provide assistance with referrals and case management for pregnant teens. PIHB and CASH continue to collaborate with other District agencies and key stakeholders to seek additional funding to sustain and expand existing programs.
/2013/
Efforts continue to focus on prevention of unplanned births and teen pregnancy, outreach to identify pregnant women and to assist their early entry into prenatal care, home visits to maintain women in care throughout delivery and the inter-conceptual period, and post-delivery home visits and infant assessments. CHA operates the Safe Cribs program. During FY 2011, the program lost the funding from First Candle through the Bill and Melinda Gates Foundation. Although the loss of funding hampered the program's ability to purchase standard cribs, the purchase and distribution of pack-n-plays continues. In FY 2011, 66 standard cribs and 927 pack-n-plays were given to families in need that would otherwise bed-share with their infants. A number of these families reside in shelters and transitional housing. The number distributed represents more than 10% of the resident births in CY 10. Recipients are required to complete a 2-hour workshop on Sudden Infant Death Syndrome (SIDS)/Safe Sleep. In partnership with the Office of Latino Affairs Spanish language SIDS/SIDA workshops are offered. During 2011, 255 participants attended a SIDS education session. //2013//

2. Enhance nutrition and increase physical activity for children and youth through increased access to healthy foods and physical activity opportunities and through breastfeeding promotion. (ES)
The NPFB enhanced the District's farmers markets efforts by recruiting 18 new farmers, certifying 5 new markets, registering 7 new farm stands and farmers on Wheels, and authorizing 45 farmers to redeem WIC Cash Value Checks for produce. Bus and rail campaigns advertised the new WIC food packages and NPFB is expanding those efforts to include information on eligibility, certification, and authorized vendors and cashiers. NPFB is working to promote employer supported breast feeding areas in compliance with amendment to the Fair Labor Standards Act. Other efforts include providing health education and promotion efforts for SNAP-ED and collaborating with Medicaid to provide guidance to health care providers regarding obesity related services.
/2013/
Beginning in 2007 CHA staff organized a group of community leaders to address childhood obesity. The mission later expanded to include adults and the Obesity Task Force developed an action plan in 2009-2010. Funds for implementation were appropriated by the city council, eventually supplemented by a CDC grant and the Preventive Health Services Block Grant. Examples of approaches taken to reduce the prevalence of obesity included funding several small mom and pop stores located in food deserts to install health corners stocked with fresh fruits and vegetables and the establishment of 10-minute activity recesses. Over the past months, staff has initiated discussions with Medicaid staff on ways to encourage primary care providers to better address patients' obesity. Dedicated funding for obesity reduction ends with this fiscal year. Managers are in the process of convening a meeting with staff to consider how to sustain (and possibly enhance) on-going efforts.

The DC Parks Prescription program was developed in collaboration with the DC Department of Health/CHA, the DC Chapter of the American Academy of Pediatrics (DCAAP), and the National Parks Service, Unity Upper Cardozo Clinic and Children's National Medical Center. It is an initiative to encourage pediatricians to "prescribe" overweight/obese youth and those diagnosed with ADHD to spend time in parks. The partnership has developed a standardized park assessment tool with which all parks in DC will be assessed for accessibility to public transportation, ADA accessibility, structured activities and amenities. From these assessments a flyer for each park will be produced and then organized according to quadrant into a tool kit. When the prescription is written, the toolkit will also be provided, assisting youth and their families with information on resources for physical activities. A pilot project is waiting IRB approval for Unity Upper

Cardozo and Children's Good Hope Road for the summer 2012, where parents and physicians will be surveyed pre and post, to see if the toolkit actually increases time in parks. Pending results of the pilot, a finalized citywide toolkit will be completed September 2012 for kick-off and release. //2013//

3. Reduce teen pregnancy. (PBS, DS)
The school nurse program will continue health and sexuality education to DC Public Schools students. CHA will evaluate the "Girl Talk" and "Healthy Generations" sub grantee program and determine their success in mitigating teen pregnancy and improving parenting skills of teen mothers. CHA will continue to present Health and Sexuality Education Programs at various DCPS and a few Charter Schools as well as the Woodson Adolescent Wellness Center that will continue to provide health and sexuality education, comprehensive health services, and pregnancy prevention programs. CHA will periodically collect and analyze data related to
maternal and child health, including but not limited to metabolic screening, newborn hearing, case management of pregnant teens, infant mortality. CHA will develop a Youth Action Plan that includes prevention or increasing teen pregnancies and monitoring and surveillance of maternal child services.

/2013/
CHA supported two teen pregnancy prevention efforts in 2011-2012: the Howard University Hospital, Daughters Influenced by the Intelligent Voices of Adults (DIVA) and the Carrera Adolescent Teen Pregnancy Prevention program model. The Carrera program was implemented in partnership with the Arts and Technology Public Charter School (ATA) and managed by Opportunities Industrialization Corporation (OIC). DIVA was designed to increase the inter-pregnancy interval (child spacing) among teenage mothers by reducing the rate of subsequent births within a 24 month time period. They documented zero reports of repeat positive pregnancies among participants during the grant period. They assisted 5 graduating seniors and 8 underclasswomen to identify the number of credits and volunteer hours required to successfully complete Calvin Coolidge SHS. They assisted 5 graduating seniors attending Calvin Coolidge SHS with identifying colleges and universities offering a Single Parent Support System (Saint Paul College, Smith College, Wilson College and Endicott College). They identified 17 pregnant/parenting teen mothers who actively participate in DIVA to attend the Howard University Annual Holiday Celebration.

OIC operates the Carrera Program in DC. OIC enrolled 72 new program participants and completed a successful summer enrichment camp with 53 youth participant: 12 received dental services and 28 received medical services. 100 participants [unduplicated] met with licensed clinical social worker for counseling services as needed. OIC/DC Carrera made 100 referrals for wrap-around services (social, emotional, housing, clothing etc.) All participants, regardless of program location, were able to take part in Job Club, Individual Lifetime Sports, Family Life and Sexuality Education, and Mental Health power group. //2013//

4.Increase access to medical homes for CYSHCN and support coordinated, family-centered systems of care. (IBS, DS)
CHA will continue to collaborate with the DC Primary Care Association, National Alliance to Advance Adolescent Health and the DC Public Schools to implement medical homes to support seamless and coordinated systems of care for District residents, including children with special health care needs. CHA will support strategies to ensure that youth and parents are informed about transition and are involved in transition planning CHA will support the development of a health care transition website with resources for teens, parents and caregivers, and heath care providers. CHA will identify opportunities to implement an enhanced reimbursement model for practices
meeting at least level one of the Physician Practice Connections Patient Centered Medical Home recognition program.

/2013/
CHA provided funding to build new community health centers in 2012. They will provide expanded access to primary care for adults and children. //2013//

5. Reduce morbidity due to asthma among children and youth. (ES)
CHA will continue the community collaborative efforts with United Medical Center/Breathe-DC and DHCF Chronic Care Collaborative Asthma Initiative to promote asthma education and tobacco cessation activities. CHA will continue to collaborate with CNMC to promote the electronic standardized asthma assessment tool, including adaptation of the tool as an open source application; and distribution to other DC providers. CHA will continue to collaborate with DDOE to identify children at risk for lead and dust exposure that may trigger asthma symptoms. School nurses will identify children with asthma and develop a care plan that permits children to self medicate for asthma during the school day. CHA will continue to collaborate with IMPACT DC that provides asthma education in schools and community outreach directly to students. CHA will develop an information technology strategy to
transfer and make available the electronic asthma assessment tool to providers.
/2013/
See the description above under health capacity. //2013//

6. Reduce violence and injury among children and youth. (PBS, DS)
CHA will develop a Youth Action Plan to address issues specific to the youth population which will focus on mood and behavioral health issues, intentional injury and suicide prevention; truancy; chronic illnesses; etc. CHA will collaborate with MPD, DYRS, DMH, and other agencies, providers and advocate to address the issues related toward and by children and youth.

/2013/
Under the CASH Bureau, the Violence Prevention Education Program was developed to reduce the incidence of first time victims of sexual assault in Wards 7 and 8 through providing sexual violence education with the intent to transform attitudes and behaviors of students towards sexual violence. Information from various evidence based curriculums, such as Safe Dates and Good Touch Bad Touch, and internet sources are utilized. Topics include rape prevention, child abuse prevention, bullying, and healthy relationships. The Violence Prevention Education program awarded two sub grants to conduct violence prevention work in Wards 7 and 8. In April 2011, the DC Rape Crisis Center sponsored the 2011 Sexual Assault Awareness Month (SAAM). The objectives were to (1) raise awareness of sexual violence and its' impact, (2) provide educational opportunities for survivors and the community at large, (3) conduct outreach to various underserved communities in D.C. The DC Rape Crisis Center met these objectives by coordinating and implemented 25 presentations. Men Can Stop Rape implements Men on Strength (MOST) Club programming in District public middle schools and high schools in Wards 7 & 8. Goals of the MOST Clubs this year were to: (1) facilitate MOST club member participation in monthly Community Strength Projects; (2) Utilize Strength Media materials; (3) Conduct trainings for professionals; and (4) hold workshops for parents.

In March 2012 Mayor Vincent Gray announced the District's first city-wide Anti-Bullying Action Plan, led by the DC Office of Human Rights (OHR).//2013//

7. Improve oral health among children, youth and pregnant women. (PBS,DS)
DOH developed the first statewide oral health plan to improve oral health in the District. DOH operates the school based oral health program through partnerships with Howard University College of Dentistry, CNMC Dental Pediatric Residency Program and St Elizabeth Hospital Dental program.

CHA is partnering with the DC Board of Dental Licensing to address policies such as allowing non-dental providers to administer fluoride varnish to children. Other activities include: expanding community water fluoridation; expanding fluoride varnish and dental sealant programs in DC

public schools; establishing an oral health network to develop local solutions to access problems; as well as improving data collection and tracking.

/2013/
The Oral Health Workgroup section of the DC City Wide Pediatric Forum is now a nonprofit 501(c) 3 called the DC Pediatric Oral Health Coalition. CHA will provide funding to renovate and build new health centers that expand dental services as part of their service plan. Dental screening and treatment is a required part of Medicaid's EPSDT benefit. In FY 2013, the District is moving toward payment for fluoride varnish treatment for young children under 3 and continues to place strong emphasis on the importance of oral health care for the District's children.

The school based oral health program continues to provide oral health services to children ages 6 through 9. Kid Smiles also performed visual oral health screenings on 2,200 plus kids in the DCPS and charter schools, ages from 3 to 12 years of old and reported an average decay rate of over 40%.
//2013//

8. Reduce sexually transmitted infections in adolescents. (PBS, DS)
CHA will continue to provide HIV/AIDS and sexually transmitted diseases screening and prevention services for adolescents. It will continue to collaborate with DC Public School and Charter Schools --School Nurse program and HAHSTA to screen and counsel adolescents. School nurses will continue its health and sexuality education programs.

/2013/
CHA will continue to increase the number of adolescents screened for STIs. It was agreed in the internal stakeholders meeting that school-based health centers should provide education to students on STIs. The School-based Screening Project (SBSP) and the Summer Youth Employment Program (SYEP) screening project, along with the revamping of the Gonorrhea Screening Program (GSP) gained the Bureau of Sexually Transmitted Diseases Control access to more youth and youth at highest risk to offer testing. Partnering with community-based agencies that provide services to adolescents, the Bureau provided information and voluntary, confidential urine based screening for youth in the target age-groups. These projects resulted in a greater access to STD clinical services, opportunities for increased health-seeking behaviors, and increased risk-reduction counseling for DC's youth. Consideration is being given to funding STI services at the health centers.

According to the DOH HAHSTA Annual Report 2011, the SBSP routinely screens "thousands" of senior high school (grades 9 through 12) students for chlamydia and gonorrhea. Expanded screening efforts have resulted in an increase in reported infections. From 2006 to 2010 the District received 28,461 reports of chlamydia infections. Among those, 69.1% were between 15-24 years of age. Reported chlamydia cases more than doubled from 2006 (3,360) to 2008 (6,899) but have leveled off since then. Epidemiologists indicate that the increase is likely due to expanded screening programs among high-risk populations, including senior high school students, and more sensitive diagnostic tests that are performed on urine specimens that can be collected in nontraditional venues (such as high schools and non-clinical community programs) and are more effective at detecting infections. In 2006, 36.9% of reported chlamydia cases were among 15-19 year olds. In 2010, 42.0% were reported among this same age category. In 2006, 26.4% of reported gonorrhea cases were among 15-19 year olds. In 2010, 35.3% were reported among this same age category. //2013//

9. Increase lead screening for children under six years of age. (PBS)
This is an existing state measure which must be continued as a priority.
Continue to screen children at 12 and 24 months per DC law. DDOE will continue its collaborate

efforts with PIHB and NPFB to identify women and children at environmental risk ad provide environmental screening for lead and dust; track children's lead screening and reporting; implement the new CDC Healthy Homes Preventive Poisoning System (HHPPS) to track lead and other environmental exposures; and provide case management to children at risk for lead poisoning and test sources of lead contamination. CHA will collaborate with Medicaid to identify opportunities for increasing lead.
/2013/
See state performance measure #6.//2013//

10. Improve surveillance and monitoring of maternal and child health. (IBS)
Under the Patient Protection and Healthcare Act, CHA will identify Federal grant opportunities for data collection and integration. CHA plans to hire an epidemiologist to assist with analysis of Title V data from disparate sources and to counsel sub grantees in data collection and reporting of data.
/2013/
The SSDI grant application, which is submitted concurrently with this Title V application, describes preliminary plans to install a data warehouse in FY 2013 to include data sets from various CHA programs. The DC Medicaid program will be asked to contribute Medicaid recipient and claim detail data for appropriate age and population groups. Finally, DC Public Schools (Office of State Superintendent of Education) will be asked to contribute school population data. //2013//

An attachment is included in this section. IVB - State Priorities

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	100	98	90	95	100
Annual Indicator	100.0	86.0	100.0	100.0	100.0
Numerator	30	43	40	55	32
Denominator	30	50	40	55	32
Data Source		Newborn Screening Program	Newborn Screening Program	Newborn Screening Program	Newborn Screening Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

	2012	2013	2014	2015	2016
Annual Performance Objective	100	100	100	100	100

Notes - 2011
Each year nearly all positive screened newborns are identified and referred to follow-up services. However, there is not a tracking system to identify the progress genetics service providers are having with identified clients. The District of Columbia intends to rectify this issue.

Information provided by the Community Health Administration's Newborn Screening Program for Metabolics and Genetics traits. Information includes newborns born in 2011 and screened by Pediatrix - a contract laboratory.

Notes - 2010
Information provided by Newborn Metabolic Screening Program. Total number of newborns served in 2010.

Notes - 2009
Program identified 41 newborns with confirmed presumptive positives. All of them entered treatment. The breakdown is as follows:

Acylcarnitine 1
Amino Acid 1
CAH 17-OHP 0
Cystic Fibrosis 1
Biotinidase Deficiency 1
Congenital Hypothyroidism 6
Hemoglobinopathies 31
Galactosemia 0
TOTAL 41

a. Last Year's Accomplishments
In 2010 the District of Columbia screened 85.1% of newborns born in DC birthing hospitals and/or residents of the District for metabolic or genetic conditions. Because DC resides in a tri-state area nearly half of the District's occurrence births involve out of state residents. Newborn screening results are produced by a contract laboratory in Pennsylvania -Perkin Elmers. Positive screenings are faxed both to the screening facility and CHA's program. The District's newborn screening program has agreements on sharing positive screenings with Maryland and Virginia, but does not have agreements with sharing overall screening information. Annually, CHA builds a file of monthly screenings and converts it to a newborn based file. This year children born in 2010 and screened were linked to the 2010 Occurrence birth to examine program reach.

Program identified 1185 newborns with confirmed presumptive positives. All of them entered treatment. The breakdown is as follows:
Aclycarnitine 0
Amino Acid 2
CAH 17-OHP 0
Cystic Fibrosis 0
Biotinidase Deficiency 4
Congenital Hypothyroidisms 3
Hemoglobinophathies (sickle cell trait) 694
Hemoglobinophathies (sickle cell disease) 27
Galactosemia 0
G6PD 455
Total 1185

1. Continued follow-up for children with abnormal screens through case management to ensure that each infant born in a District hospital who receives an abnormal newborn genetic/metabolic screening receives short term follow up from identification to specialty referral. These infants are followed to diagnosis. The PIHB started to develop and implement a process for long-term follow up, allowing care coordinators to provide enhanced follow up beyond disorder identification to ensure comprehensive, coordinated care and treatment of affected infants. Early identification and appropriate and continuous treatment is vital to addressing the morbidity and mortality of these infants.
2. Continued social media campaign that included new born screening.
3. Participated in Fetal Alcohol Syndrome and Disorders symposium

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continuing follow-up for children with abnormal screens with case management to ensure that each infant born in a District hospital who receives an abnormal newborn genetic/metabolic screening receives short term follow up of identified cases for ref	X		X	
2. Continuing social media campaign.		X	X	
3. Working with DOH leadership and Advisory Board to get Severe Combined Immunodeficiency (SCID) screening added to the disorders screened for in the District. This can be done through promulgation of regulation; new legislation is not required.		X	X	X
4. Continuing to work with Children's National Medical Center to have all newborns born in the District screened for Critical Congenital Heart Disease (CCHD). The grant submitted by CCHD to MCHB for a pilot project was not funded and the extent to which	X	X	X	
5. With support from SAMHSA, developed the Fetal Alcohol Spectrum Disorder (FASD) State Plan, which was submitted to the FASD Center for Excellence on October 30, 2011.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
1. Continuing follow-up for children with abnormal screens with case management to ensure that each infant born in a District hospital who receives an abnormal newborn genetic/metabolic screening receives short term follow up of identified cases for referral. These infants are followed to diagnosis.
2. Continuing social media campaign.
3. Working with DOH leadership and Advisory Board to get Severe Combined Immunodeficiency (SCID) screening added to the disorders screened for in the District. This can be done through promulgation of regulation; new legislation is not required.
4. Continuing to work with Children's National Medical Center to have all newborns born in the District screened for Critical Congenital Heart Disease (CCHD). The grant submitted by CCHD to MCHB for a pilot project was not funded and the extent to which progress can be made without additional resources has yet to be determined.
5. With support from SAMHSA, developed the Fetal Alcohol Spectrum Disorder (FASD) State Plan, which was submitted to the FASD Center for Excellence on October 30, 2011

6. Informed staff of community based maternal and child health services organizations and Healthy Start clients on the dangers of drinking alcohol while pregnant.

c. Plan for the Coming Year

1. Continue social media campaign to promote healthy babies, healthy women and healthy fathers.
2. Continue to provide case management for newborns with a positive screen through diagnosis, referral to treatment and closure of referral. Conduct home visits as necessary to ensure diagnosis and follow up. For families that require additional support, enroll infants in a case management program.
3. Finalize addition of SCID to screening panel. Advocate for adequate coverage by DHCF for hospitals.
4. Contact medical associations and arrange information and education for physicians on SCID.
5. Work with DC Medical Society and local chapter of ACOG on guidance for drinking alcohol during pregnancy

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**13788**					
Reporting Year:	**2010**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	11729	85.1	3	1	1	100.0
Congenital Hypothyroidism (Classical)	11729	85.1	7	1	1	100.0
Galactosemia (Classical)	11729	85.1	1	1	1	100.0
Sickle Cell Disease	11729	85.1	26	26	26	100.0
Biotinidase Deficiency	11729	85.1	0	0	0	
Cystic Fibrosis	11729	85.1	1	1	1	100.0
Carnitine Uptake Defect	11729	85.1	6	3	3	100.0
Dehydrogenase deficiency (G6PD)	11729	85.1	345	345	0	0.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	58	58	58	58	58
Annual Indicator	53.1	53.1	53.1	53.1	67.3
Numerator					
Denominator					
Data Source		CSHCN survey	CSHCN survey	CSHCN survey	CSHCN survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	77	77	77	77	77

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2009
The next survey began in 2009. Data has not been posted on the website and when the 2009 data becomes available, this measure will be updated.

a. Last Year's Accomplishments
Since data from the 2005/2006 and 2009/2010 CSHCN surveys for this question are not comparable, no statement can be made about change in satisfaction. However, more than two-thirds of families indicated that they are partnering in decision making and are satisfied with the services they receive. The District exceeded its 2011 Title V performance on this measure. Strategies included:
1. Promoted the "I Am A Healthy DC Baby" public awareness campaign.
2. Awarded a sub-grant to Advocates for Justice to develop and implement the Parent Information

Network to support families' partnering in decision making at all levels.
3. Managed Care Organizations provided care coordination, support group meetings, educational sessions and mailings, service satisfaction surveys, community forums, and supported for children and youth to attend camps during the summer.
4. Continued collaboration with DDOE Lead Family Education Program to educate families on how to mitigate dust and lead in homes.
5. Selected CSHCN parent advocate to attend AMCHP and present before the CHA director and bureau chiefs.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Monitor and evaluate the Parent Information Network sub grantee.				X
2. Continue to support the CSHCN Advisory Board			X	X
3. Engage with the DHCF to review funding streams for privately insured patients whose coverage does not adequately cover all medical needs.	X	X	X	
4. Continue to explore strategies with OSSE to improve follow-up with children with positive hearing results. Continue to provide literature to parents whose child did not have a hearing screening.		X	X	X
5. Translated the DC Hears brochures into Spanish.	X		X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities
1. Monitor and evaluate the Parent Information Network sub-grantee.
2. Continue to support the CSHCN advisory board.
3. Continue to explore strategies with OSSE to improve follow-up with children with positive hearing results. Continue to provide literature to parents whose child did not have a hearing screening.
4. Translated the DC Hears brochures into Spanish.

c. Plan for the Coming Year
1. Continue to work with parent advisory groups and advocacy organizations such as the Parent Information Network and families with asthma.
2. Encourage the participation of all families (especially those that are non-traditional) in decision making, learning and advocacy.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	44	44	40	40	40.5
Annual Indicator	36.9	36.9	36.9	36.9	34.2
Numerator					
Denominator					
Data Source		CSHCN survey	CSHCN survey	CSHCN survey	CSHCN survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	35	40.5	42.5	45.5	50

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010. Therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2009
The next survey began in 2009. Data has not been posted on the website and when the 2009 data becomes available, this measure will be updated.

a. Last Year's Accomplishments
Reported participation in a medical home in 2011 was 34.2%, continuing to be below the annual objective. As indicated in the data notes, data across the survey cycles are not comparable.

26% of parents served through AJE's DC Parent Information Network (DCPIN) reported attachment to a medical home providing coordinated, ongoing, comprehensive care. In support of the parents AJE serves, the DCPIN offered 49 trainings during the 2010-2011 reporting period. Some topics covered included: Sickle Cell Anemia, Understanding the 504 Process and Specific Health Conditions, What is a Medical Home, DC Health Insurance 101, Tips on Building Your Child's Medical and Educational File, Understanding Communication Disorders and Sexuality and

Children with Special Healthcare Needs (What Parents Should Know). These trainings were offered to parents, caregivers and professionals in English. Many sessions were offered in Spanish as well.

Building on the medical home transition efforts that began in 2009, CHA continued to support The National Alliance to Advance Adolescent Health to continue the 5-site transition learning collaborative that is implementing the new clinical recommendations jointly developed by the AAP/AAFP/ACP. The sites include 3 pediatric sites (CNMC-Adolescent Clinic, CNMC-Adams Morgan Clinic, and Georgetown Adolescent Clinic) and 2 adult sites (from Howard University Hospital's Family Medicine Clinic, and George Washington's Internal Medicine Clinic). At each site, staff focused special attention on youth enrolled in Health Services for Children with Special Needs (HSCSN), DC's Medicaid managed care organization for children and youth with disabilities.

In 2011, The National Alliance held 2 intensive 1 1/2 day learning collaborative sessions with the 5 teams and had Carl Cooley and Jeannie McAllister, from the National Health Care Transition Center (NHCTC), as trainers. They have also involved other local and national experts to address HIT, guardianship, and other issues. In addition, monthly coaching calls and on-site technical assistance is provided by The National Alliance team. Each site put in place the 6 core elements of transition, which include a formal transition policy, a transition registry, transition readiness assessments, transition action plan, medical summary, and a transfer checklist. To evaluate progress, each practice completed the NHCTC medical home transition index in 2010 and again in 2011. This index is a self-assessment tool that corresponds to the 6 core elements and allows practices to report on their level of progress. Also, in 2011, transition grand rounds were held at Georgetown, with more than 100 physicians, residents, and nurses in attendance.

In DC, a transition website was developed by School Talk and had mostly education-related transition information. The National Alliance, in collaboration with School Talk, created a new set of content on health care transition for youth, families, and health care providers. This is now available on www.dctransition.org. Developed for the learning collaborative and this website was a list of community support resources for youth and families with special needs. In the fall of 2011, a citywide fair was held on transition, and The National Alliance was among the 50+ groups available with resource information to youth, families, and school officials.

With HSCSN and the DC chapters of the AAP, AAFP, and ACP, a planning committee was formed to plan a CME transition training program in 2012 and completed all of the necessary documentation to obtain CME credits for participants.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue support of The National Alliance to Advance Adolescent Health (NAAAH) to continue medical home transition learning collaboratives.	X	X	X	
2. CHA and HSCSN and local associations are funding health care transition CME programs				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
CHA has continued its support of NAAAH to continue the medical home transition learning collaborative. NAAAH also continues to offer monthly coaching calls and on-site transition support. Incorporating transition quality improvements into ongoing clinical processes and electronic health records in large academic practices is a major undertaking. With each of the 5 teams, NAAAH is encouraging continued progress, problem-solving assistance, and expansion to other clinicians in these large systems. All of the sites have now had transition grand rounds; CNMC-Adams Morgan has expanded transition efforts to the Shaw Clinic. CNMC has started a transition special interest group within the institution and has just been awarded a major federal grant to evaluate whether transition influences health outcomes. All of the sites have been presenting on transition within their institutions to residents and other medical, nursing, and social worker leaders, and they have begun to present their innovative efforts at national meetings.

Health care transition CME programs will be held, jointly sponsored and funded by CHA, HSCSN, and the DC Chapters of the AAP, AAFP, and ACP. Other transition training opportunities are planned, including a plan for working with school nurses and with HSCSN's care coordinators.

c. Plan for the Coming Year
1. Expand the number of clinics/practices participating and involve the DC experts that have completed extensive training on transition --including members of the 5 teams and parent and youth leaders. Staff plans to focus special attention within the 5 sites and HSCSN on implementing transition improvements, and making necessary enhancements, for youth with mental health conditions. This population's needs will require expansion of the collaborations to other DC public and private organizations involved in their care.
2. Work with DC Partners in Transition, a DC organization focused on special education and transition, to expand its focus as a DC interagency work group on transition and include health and mental health and to develop a strategic plan, building on the lessons learned from other states that have formed interagency transition work groups.
3. Work with DHCF and the major public and private insurance plans and with local pediatric, family medicine, and internal medicine clinical leaders and local chapters to improve quality of care for CYSHCN.
4. Identify and use additional training opportunities, including with the school nurses and DCPCA and Advocates for Justice and Education.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	62.5	62.5	63	63	63
Annual Indicator	62.7	62.7	62.7	62.7	65.8
Numerator					
Denominator					
Data Source		CSHCN survey	CSHCN survey	CSHCN survey	CSHCN survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over					

the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	72.3	72.3	72.3	72.3	72.3

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2009
The next survey began in 2009. Data has not been posted on the website and when the 2009 data becomes available, this measure will be updated.

a. Last Year's Accomplishments
According to the data from the CHSCN survey and comparing 2005/2006 to the 2009/2010 survey, there has been a 5% increase in the percent of respondents who reported they have adequate private/public insurance coverage to pay for services needed. Nearly 2/3 of families reported adequate coverage. The PIHB continued the Healthy Start Program and MOM van outreach efforts to enroll pregnant and parenting women in service programs provided free of charge. The Medicaid program provided services via a carve-out managed care organization, HSCSN or fee-for-services to children who qualify. Children who do not meet those qualifications can likely qualify for the Medicaid-SCHIP programs.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue Healthy Start case management program that facilitates access to DC services and Benefits.	X			
2. Continue monitoring referrals for children with positive hearing screens for follow-up Services.	X		X	X
3. Continue to work with parent advocacy groups that train parents in how to obtain needed services			X	X
4.				
5.				
6.				
7.				
8.				

9.				
10.				

b. Current Activities
CHA staff are:
1. Continuing Healthy Start case management program that facilitates access to services and benefits, particularly assistance in enrolling in and maintaining enrollment in Medicaid-SCHIP.
2. Continuing to work with parent advocacy groups that train parents in how to obtain needed services.

c. Plan for the Coming Year
CHA will:
1. Continue the Healthy Start Program and MOM Mobile unit outreach efforts to enroll pregnant and parenting women in entitlement programs.
2. Continue the collaboration with Department of Corrections and DC shelters to provide services to pregnant women and coordinate access to services and benefits.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	73	73	90	90	90
Annual Indicator	88.8	88.8	88.8	88.8	65.5
Numerator					
Denominator					
Data Source		CSHCN survey	CSHCN survey	CSHCN survey	CSHCN survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	90	90	90	95	95

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as

survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2009
The next survey began in 2009. Data has not been posted on the website and when the 2009 data becomes available, this measure will be updated.

a. Last Year's Accomplishments
Since the questions were revised for each survey, responses are not comparable over time and no statement about change can be made. However, slightly less than two-thirds of families reported that community based systems are organized so that they can use them easily.

1. Continued collaboration with the MCOs and DHCF.
2. Expanded the Parent Information Network program to include training parent peer counselors to facilitate navigation services to more than 100 families of special needs children.
3. Awarded a sub-grant for Youth in Transition with Epilepsy and Seizure Disorders.
4. Convened Children with Special Health Care Needs Advisory Board comprised of parents, advocates and providers; developed strategic plan and held a mini retreat related to the Advisory Board organization.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Collaborating with Department of Health Care Finance to support increased efforts for well child visits			X	X
2.				
3. Collaborating with Children's with the implementation of the HRSA funded pilot program for Family Navigators that will work with families of children with special needs.	X	X	X	
4. Monitoring, evaluating, and counseling sub grantee Advocates for Justice and Education on the DC Parent Information Network.				X
5. Monitoring 4 summer camps for children with special needs	X	X	X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities
CHA staff are:
1. Collaborating with MCOs and with DHCF to support increased efforts for well child visits
2. Partnering with CNMC on the implementation of the HRSA funded pilot program for family navigators to work with families of children with special needs.
3. Monitoring, evaluating, and counseling sub-grantee Advocates for Justice and Education while developing the DC Parent Information Network.

4. Funding and monitoring 4 summer camps for children with special needs.

c. Plan for the Coming Year
CHA will:
1. Continue to collaborate with MCOs.
2. Collaborate with the DHCF to identify issues that prevent use of community based services.
3. Continue to collaborate with CNMC in the implementation of the HRSA-funded pilot program for family navigators.
4. Collaborate with DC Family Voices and the DC Parent Information Network to help identify and reduce barriers to utilization of community based systems of care.
5. Manage CYSHCN grants that include Georgetown University, Mary's Center and CNMC to assist with sustainability.
6. Continue participation in the CSHCN Advisory Board.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	8.5	9	25	25	25
Annual Indicator	24	24	24	24	33.8
Numerator					
Denominator					
Data Source		CSHCN survey	CSHCN survey	CSHCN survey	CSHCN survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	37.6	37.6	40	45	50

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as

survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2009
This is an interim year for the CSHCN survey and indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey. The next survey is scheduled to begin in 2009.
2005/2006 Revisions & Changes:
In the 2005-2006 version of the NS-CSHCN, significant wording changes and new additions were made to the set of questions used to assess Transition to Adulthood. The result is an improved and more robust assessment of this important concept. The 2001 version of the outcome is based on CSHCN ages 13-17; the 2005/06 outcome is calculated for CSHCN ages 12-17. Take these changes into consideration when comparing results across survey years. See Additional Notes section below for more details.
Additional Notes:
The Transition to Adulthood summary measure is a composite score derived from two different subparts based on 8 different survey items. Technical expert panel review of the 2001 NS-CSHCN methods for assessing transition to adulthood led to significant revisions and additions to the 2005-2006 version of these questions. In particular, filter questions were added to identify CSHCN who needed the services being assessed and a new question was added to assess whether health care providers help CSHCN to take increasing responsibility for self-care.

The next survey began in 2009. Data has not been posted on the website and when the 2009 data becomes available, this measure will be updated.

a. Last Year's Accomplishments
Over time, this indicator has been the one with the lowest satisfaction levels. Although satisfaction with transition increased from only 24% in 2004/2005 to nearly 34% in 2009/2010, clearly more remains to be done. CHA and others in the community have established several efforts to assist youth with their transition to adult services. See measure 03 above.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CHA and HSCSN and local associations are funding health care transition CME programs				X
2. Support the National Alliance to Advance Adolescent Health (NAAAH) to continue medical home transition learning collaboratives.				X
3.				
4.				
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities
See description of measure 03 above.

c. Plan for the Coming Year
DCPIN plans to increase this percentage of parents served by at least 50% in 2013. The staff plans to achieve this by ensuring that every participant in the DCPIN program is linked to a medical home, or at least receives information on medical home attachment.
See description of measure 03 above.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	82	82	90	90	82.5
Annual Indicator	83.4	72.4	75	81.2	81.2
Numerator					
Denominator					
Data Source		CDC NIS	CDC NIS	CDC NIS	CDC NIS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	82.5	82.5	82.5	82.5	82.5

Notes - 2011
The 2011 data is not available, instead 2010 data is used to populate this measure. When the data becomes available, this measure will be updated.

Notes - 2010
Children in the Q1/2010-Q4/2010 National Immunization Survey were born from January 2007 through July 2009.
4:3:1 plus 3 or more doses of Hib vaccine of any type, 3 or more doses of HepB vaccine, and 1 or more doses of varicella vaccine.

Source: CDC National Immunization Data

Date Accessed: April 30, 2012

Notes - 2009
Based on the 2009 percent, this District expects that by 2015 the percent of children immunized will increase by ten percent (82.5) .

Children in the Q3/2008-Q2/2009 National Immunization Survey were born between 2006 and 2008.
Estimates are based upon (the immunization schedule) 4:3:1:3:3 plus 1 or more doses of varicella vaccine.

SOURCE: Center for Disease Control and Prevention's National Immunization Survey
http://www2a.cdc.gov/nip/coverage/nis/nis_iap2.asp?fmt=r&rpt=tab27a_431331_race_iap&qtr=Q1/2009-Q4/2009

Date Accessed: May 2, 2011

a. Last Year's Accomplishments
Between 2009 and 2010 the percent of 19-35 month olds who received the full schedule of immunizations increased from 75% to 81.2%.
Efforts included:
1. Expanded the public information campaign "I am a Healthy DC Baby" to include a component on the importance of screenings and immunizations.
2. Maintained levels of immunization compliance in public and charter schools as well as in licensed child development centers and Head Start centers.
3. Distributed vaccines to health care providers enrolled in the Vaccines for Children program.
4. Managed the District-wide immunization registry which warehouses all of the immunization data for the District.
5. Conducted immunization trainings and conferences for providers.
6. Supported the efforts of the Immunization Coalition of Washington, DC.
7. Healthy Start case managers monitored infants' immunizations schedules and followed up with parents.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Won 3 National Immunization Survey (NIS) Awards in 2012. “State with the Highest Childhood Immunization Coverage” – 80.8%; “State with the Highest Adolescent Immunization Coverage” – which includes =1 dose of HPV (among girls) for adolescents ages		X	X	
2. Continuing to work with the public, charter, parochial, and private schools to ensure high immunization rates and working with OSSE to improve immunization rates in licensed child development centers.			X	X
3. Working with Head Start Centers to improve immunization rates.			X	
4. Working with school nurse managers to seek ways to increase rates for schools that are below the target goal of 98%. 5. Hosted a local Immunization Conference to educate providers about the ever changing world immunizations including the latest dev			X	
5. Hosted a local Immunization Conference to educate providers				X

about the ever changing world immunizations including the latest development of new vaccines and research findings on existing vaccines.				
6. Continuing to link providers with Electronic Medical Records (EMR) to the Immunization Registry so that more records can be submitted electronically to the Registry.		X		X
7. Working with the DC Immunization Coalition to engage new partners and provide support for the activities that are conducted by the Immunization Program.			X	X
8. Working with the DHCF to improve immunization rates and provider compliance with the Vaccines for children (VFC) Program.		X	X	
9. Assuring the maintenance of the Immunization Registry.				X
10.				

b. Current Activities

1. Won 3 National Immunization Survey (NIS) Awards in 2012. "State with the Highest Childhood Immunization Coverage"; "State with the Highest Adolescent Immunization Coverage"; and highest coverage for pneumococcal vaccine for high risk adults 18-64 years.
2. Continuing to work with the public, charter, parochial, and private schools to ensure high immunization rates and working with OSSE to improve immunization rates in licensed child development centers.
3. Working with Head Start Centers to improve immunization rates.
4. Hosted a local Immunization Conference to educate providers about the ever changing world immunizations including the latest development of new vaccines and research findings on existing vaccines.
5. Continuing to link providers with Electronic Medical Records (EMR) to the Immunization Registry so that more records can be submitted electronically to the Registry.
6. Working with the DC Immunization Coalition to engage new partners and provide support for the activities that are conducted by the Immunization Program.
7. Working with the DHCF to improve immunization rates and provider compliance with the Vaccines for Children (VFC) Program.
8. Assuring the maintenance of the Immunization Registry. The Immunization Registry is available via read-only access for immunization status review. The registry allows school nurses to identify those students who are out of compliance and provide that documentation to parents/guardians and school administration.

c. Plan for the Coming Year

1. Continue to work with the public, charter, parochial, and private schools to ensure high immunization rates.
2. Work with DCPS to develop strategies to ensure current immunization compliance rates throughout the District of Columbia.
3. Develop an interoperability mechanism between the Immunization Registry and Electronic Medical Record systems for bi-directional communication.
4. Work with Head Start Centers to improve immunization rates.
5. Work with school nurse managers to seek ways to increase rates for schools that are below the target goal of 98%.
6. Host local Immunization Conference to educate providers about the ever changing world immunizations including the latest development of new vaccines and research findings on existing vaccines.
7. Continue to link providers with Electronic Medical Records (EMR) to the Immunization Registry so that more records can be submitted electronically to the Registry.
8. Work with the DC Immunization Coalition to engage new partners and provide support for the activities that are conducted by the Immunization Program.
9. Work with the DCFD to improve immunization rates and provider compliance with the Vaccines

for Children (VFC) Program

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	34.1	32	40	35	38
Annual Indicator	41.1	40.4	40.3	36.8	36.8
Numerator	393	389	363	304	304
Denominator	9560	9621	9006	8250	8250
Data Source		DC 2008 Birth File	DC 2009 Birth File	DC 2010 Birth File	DC 2010 Birth File
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	33.2	33.2	33.2	33.2	33.2

Notes - 2011
The District of Columbia has a delay for reporting Birth data this year. Currently 2010 birth data is used to populate information for 2010 and 2011. When the data becomes available this measure will be updated.

Notes - 2010
Numerator: DC 2010 State Center for Health Statistics birth file.
Denominator: Denominator: US Census American Community Survey 1 Year estimates

The rate of teen age births among 15-17 year olds in the District declined by nine percent within the past two years- from 40.3 percent per 1,000 live births in 2009 to 36.8 per 1,000 live births in 2010. The District met the Healthy People 2010 and the District Title V goals of reducing the teen birth rate to no more than 40 per 1,000 live births. The District of Columbia has continued to make teen age pregnancy prevention a priority through the year 2015. Preventing teen pregnancies and repeat teen pregnancies, decreases the likelihood of school attrition, and dependence on public assistance programs and services. The Department of Health partners with community organizations, other District agencies that have and continue to implement teenage pregnancy prevention programs, abstinence prevention programs and other programs that attempt to delay the onset of pregnancy about the 15- to 17 year old population.

Notes - 2009
Source: 2009 SCHS Birthfile

At en year trend analysis showed the rate of teen age births among 15-17 year olds in the District

declined by 40 percent since 1999, from 67 per 1,000 live births to 41.1 per 1,000 live births achieving the Healthy People 2010 goal of reducing the teen birth rate to no more than 40 per 1,000 live births. The District of Columbia has continued to make teen age pregnancy prevention a priority through the year 2015. Preventing teen pregnancies and repeat teen pregnancies, decreases the likelihood of school attrition, and dependence on public assistance programs and services. The Department of Health partners with community organizations, other District agencies that have and continue to implement teenage pregnancy prevention programs, abstinence prevention programs and other programs that attempt to delay the onset of pregnancy about the 15- to 17 year old population.
For 2011 through 2015, DC anticipates a ten percent decline in the number of teenage births (ages 15-17) years. DC expects that this rate should be about 36, per 1,000 live births for the population. (The ten percent decline was based on the 2008 of 40.4% rate.)

a. Last Year's Accomplishments
The rate of teen age births among 15-17 year olds in the District declined by 9% from 40.3 per 1,000 live births in 2009 to 36.8 per 1,000 live births in 2010. The District met the Healthy People 2010 and the District Title V goal of reducing the teen birth rate to no more than 40 per 1,000 live births.
CHA:
1. Continued to collaborate with WIC, Department of Corrections, shelters and school nurses to provide early identification of pregnancy and ensure timely enrollment in prenatal care for all women of child-bearing age under Medicaid and the DC Health Care Alliance.
2. Continued Health and Sexuality Education Programs at various DCPS and a few charter schools. The Woodson Adolescent Wellness Center continued to provide health and sexuality education, comprehensive health services, and pregnancy prevention programs. 5. Enhanced community-based screening and prevention services for at risk families and youth served by child protective service agency.
3. Continued to support the DCPS "Making Proud Choices Curriculum" for all high school students.
4. Monitored STD and HIV rates in the District of Columbia and partnered with HAHSTA in condom distribution and STD testing in schools. DOH actively promoted the Rubber Revolution Social Marketing Campaign via metrobus and rail signage, updates on Facebook, YouTube, and twitter sites, and displayed posters and flyers. Condoms are readily available free of charge at schools, community clinics, human services organizations, and even neighborhood businesses. In addition, school-based health centers and community health centers made reproductive health services available to teens.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Work with community partners to implement evidence based approaches to increase the age of sexual initiation.	X		X	
2. Continue health and sexuality education classes that include addressing pregnancy prevention and self awareness sessions in District of Columbia schools for grades K-12.	X		X	
3. Released the I Care About Me Campaign.			X	
4. Provided funds for the Carrera pregnancy prevention model.	X		X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. Work with community partners to implement evidence based approaches to increase the age of sexual initiation.
2. Continue health and sexuality education classes that include addressing pregnancy prevention and self awareness sessions in District of Columbia schools for grades K-12.
3. Continue to distribute and promote use of condoms.
4. Released in May 2012 the I Care About Me social marketing campaign directed at African American and Latino youth aged 16-23 "who have yet to conceive". Social media are integrated with online platforms.
5. Provide funds for the Carrera Pregnancy Prevention program model and the Howard University DIVA project, which are described in another section of this report.

c. Plan for the Coming Year

1. Continue to run and assess I Care About Me social media campaign.
2. Continue sub-grant support for Carrera Pregnancy Prevention program model.
3. Open two new school based health centers that will provide health and sexuality education, comprehensive health services, and pregnancy prevention programs.
4. Operate the school nurse program.
5. Continue to make free condoms available and to promote their use.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	65	65	80	80	88
Annual Indicator	57.6	76.4	72.6	80.7	75.7
Numerator	49	311	292	326	418
Denominator	85	407	402	404	552
Data Source		DC 2008 Oral Health Program	DC 2009 Oral Health Program	DC 2010 Oral Health Program	DC 2011 Oral Health Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	80	80	80	80	80

Notes - 2011

During the FY 2011 Fiscal Year, only seven elementary schools participated in the Oral Health Program. The majority of the students attending these schools were eligible for the free or reduced lunch program, and this was one of the criteria for the FY2011 school selection. Second

and Third graders received permission forms, and those students who returned signed forms were included in the program. Only those students that have a sealant placed were entered as the numerator. Please note the majority of students had more than one sealant placed during this fiscal year. This speaks to a greater need to stress the importance of dental hygiene among this population.

Source: District of Columbia Oral Health Program (housed in the Community Health Administration)

Notes - 2010
Source: District of Columbia Oral Health Program (housed in the Community Health Administration)

Notes - 2009
Field notes: Year 2009
Numerator: Number of 3rd graders who received a sealant
Denominator: Number of eligible 3rd graders
Data source: DC DOH Oral Health Program

This reporting period, 11 District of Columbia Public Schools were targeted to receive Oral Health services (2 fewer than last year). These schools met treatment inclusion criteria that at least one-half of students enrolled were eligible for the free or reduced lunch program; students also were required to return signed permission slips. As in previous years, the number of eligible students and those who returned permission slips remains low. The rate of returned signed consent forms fluctuates in spite of our best efforts. In 2009, the return rate was 52% for the 11 elementary schools.

The percent of 3rd graders receiving a sealant from the Oral Health program is somewhat lower in 2009 (72.6%) compared to 2008 (76.4%). It does not meet the 2009 Annual Performance Objective of 80 percent 3rd grade children to receive protective sealants on at least one permanent molar tooth.

a. Last Year's Accomplishments
The District has never been able to supply data for this measure; there is no on-going or periodic survey to yield estimates of sealant prevalence on this cohort. Instead, the Title V program continues to report on its school oral health programs. During FY 2011, seven elementary schools participated in the Oral Health Program. The majority of the students attending these schools were eligible for the free or reduced lunch program, and this was one of the criteria for the selection of schools. The number of schools in which the program was offered has declined over the past years, due to declining grant support. In the select schools, second and third graders received permission forms, and those students who returned signed forms were included in the program. Only those students who had a sealant placed were included in the numerator, while the denominator includes students who had an exam (and possibly received other services). The majority of students had more than one sealant placed during the fiscal year. From 2010 to 2011 the present of children who received protective sealants on at least one permanent tooth decreased by 6%.

As shown on Form 17, health systems capacity #07B, the percent of EPSDT eligible children aged 6 through 9 who received any dental services during the year jumped from 58% in 2010 to 67.1% in 2011, a 22% increase and a very considerable improvement from 42.5% in 2007.

Efforts included the following:
1. The School Based Oral Health Program continued to provide preventive oral health services to District of Columbia Head Start Centers and DCPS elementary school students. Students enrolled in the National Free or Reduced Lunch Program were targeted by the program. The services were free of charge to families.

2. The DOH ratified a new Memorandum of Understanding (MOU) with DCPS to permit the school based oral health program to expand its clinical treatment protocols to include invasive treatments procedures (using local anesthesia) such as teeth extractions, dental fillings and gum treatment).
3. Staff worked with a newly DOH formed Oral Health Coalition to formulate a DOH Oral Health Strategic Plan and Oral Health Burden document.
4. Staff collaborated with the DC Cancer Consortium (DCC) on oral health and continued to gather clinical and secondary oral health data.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The School Based Oral Health Program continues to provide sealant application, fluoride treatment, dental screenings, and oral health promotion services to eligible students in District of Columbia Head Start Centers and DCPS. Start Centers and DCPS.	X		X	
2. Staff ensures that parents and guardians are alerted when their child is in need of additional dental care.	X		X	
3. Staff attends PTA meetings at DCPS to increase awareness of oral health services provide at the schools.			X	
4. Implementation of the DOH Oral Health Strategic Plan began.			X	X
5. Collaboration with the DC Cancer Consortium (DCC) on oral health goals identified in the Citywide Pediatric Forum is continuing.			X	
6. DHCF approved a new policy to allow DC dental providers and licensed independent practitioners to be reimbursed by DC Medicaid for fluoride varnish applications at least 4 times per year per patient.	X			X
7. Staff is working to improve oral health literacy in the schools and to create behavioral change. Pre and post tests are given to evaluate the students' level of oral health knowledge.		X	X	
8. The District continues to provide incentives such as Student Loan Forgiveness to increase the capacity of dental health providers in underserved areas.	X			X
9.				
10.				

b. Current Activities

1. The School Based Oral Health Program continues to provide sealant application, fluoride treatment, dental screenings, and oral health promotion services to eligible students in District of Columbia Head Start Centers and DCPS.
2. Staff ensures that parents and guardians are alerted when their child is in need of additional dental care and provides the child and parent with information on dental practitioners they may visit.
3. Staff attends PTA meetings at DCPS to increase awareness of oral health services provided at the schools.
4. Implementation of the DOH Oral Health Strategic Plan began.
5. Collaboration with the DC Cancer Consortium (DCC) on oral health goals identified in the Citywide Pediatric Forum is continuing.
6. DHCF approved a new policy to allow DC dental providers and licensed independent practitioners to be reimbursed by DC Medicaid for fluoride varnish applications at least 4 times

per year per patient.
7. Staff is working to improve oral health literacy in the schools and to create behavioral change. Pre and post tests are given to evaluate the students' level of oral health knowledge.
8. The District continues to provide incentives such as Student Loan Forgiveness to increase the capacity of dental health providers in underserved areas.

c. Plan for the Coming Year
1. Continue to monitor and evaluate the School Based Oral Health Program.
2. Promote and increase awareness of the connection between oral health and childhood obesity.
3. Continue gathering clinical and secondary oral health data.
4. Implement the DOH Oral Health Strategic Plan with the Oral Health Coalition.
5. Continue to collaborate with the DC Cancer Consortium (DCC) on the Oral Cancer Plan and oral cancer mitigation efforts identified in the Citywide Pediatric Forum
6. Work on legislation to allow safety-net non-dental providers to administer fluoride varnish, caries anticipatory guidance and dental referrals during well-baby visits.
7. Evaluate efforts to improve oral health literacy and apply findings.
8. Work to increase incentives to increase capacity of dental health providers who accept pediatric DC Medicaid patients.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	2	2	3	2	1
Annual Indicator	3.2	1.1	1.1	1.2	1.2
Numerator	3	1	1	1	1
Denominator	93980	92412	94848	84119	84119
Data Source		2008 DC Death File (Vital Statistics)	2009 DC Death File (Vital Statistics)	2010 DC Death File	2010 DC Death File
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	Yes
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	2	2	2	2	2

Notes - 2011
The District of Columbia has a 2-year delay for reporting death data. Currently 2010 death data is used to populate information for 2011.

Source: Numerator: SCHS 2010 Death File
Denominator: US Census American Community Survey Population estimates for the District of Columbia

.

Notes - 2010
The rate of children aged 14 years and younger caused by motor vehicle crashes per 100,000 children remains low - 1.2. Similar low rates have occurred over a 3-year period.
Source: Numerator: SCHS 2010 Death File
Denominator: US Census American Community Survey Population estimates for the District of Columbia

Notes - 2009
Currently the number of deaths in 2009 among infants and children aged 1-14 caused by motor vehicle crashes is used to report information for 2009. The 2009 data will be available and reported in 2011.

Source Denominator: United States Census Bureau 2008 American Fact Finder Population Estimates for the District of Columbia available at: http://factfinder.census.gov/servlet/DTGeoSearchByListServlet?ds_name=ACS_2008_1YR_G00_&_lang=en&_ts=295373522343 .

Notes:

The death rate among children 1-14 years old caused by motor vehicle crashes has decreased from 3.2 deaths caused by motor vehicle accidents per 100,000 children in the District in 2007 to 1.1 motor vehicle related deaths per 100,000 children in the District in 2008. An examination of the three year trends shows a marked decrease from 4.2/100,000 in 2006, 3.2/100,000 in 2007 and 1.1/100,000 in 2009.

a. Last Year's Accomplishments
DC continued to experience few deaths due to crashes and exceeded its objective for 2010. Although CHA had intended to work to amend the Child Health Action Plan to incorporate strategies to address motor vehicle safety, the planning process was put on hold in 2012 due to changes in departmental leadership and decisions to harmonize the multiple planning efforts across the city and the department.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Promote consistent seatbelt use and support public education efforts.			X	
2. Work with APRA and community stakeholders to strengthen programs aimed at combating alcohol and drug use.			X	X
3. Promote education efforts that address the dangers of driving while using cell phones, and other forms of multi-tasking.	X	X	X	
4. Assist parents with obtaining infant and child car seats at no or low cost. .	X		X	
5.				
6.				
7.				
8.				

9.				
10.				

b. Current Activities
Efforts included:
1. Promote consistent seatbelt use and support public education efforts.
2. Work with APRA and community stakeholders to strengthen programs aimed at combating alcohol and drug use.
3. Promote education efforts that address the dangers of driving while using cell phones, and other forms of multitasking.
4. Assist parents with obtaining infant and child car seats at no or low cost.

c. Plan for the Coming Year
CHA intends to continue current activities and support youth development programs to help adolescents avoid risky behaviors.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	41	42	25	25	27
Annual Indicator	21.8	23.0	28.6	20.2	24.2
Numerator	375	486	590	408	1879
Denominator	1722	2113	2063	2018	7764
Data Source		WIC DCPedNSS System	WIC PedNSS System	WIC PedNSS System 2010	WIC PedNSS System 2010
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	27	27	27	27	27

Notes - 2011
Breastfeeding persistence at six months among the Women, Infants and Children (WIC) population has increased by twenty percent from 20.2 percent in 2010 to 24.2 percent in 2011.

Source: District of Columbia PedNSS system. This data is taken from the District's WIC population for 2011.

Notes - 2010
Source: 2010 DC Pediatric Nutrition Surveillance System (PedNSS).

Between 2006 and 2009, breastfeeding persistence at 6 months decreased by seven percent in the Women, Infants and Children (WIC) population, where the data was obtained. This was less than the Healthy People 2010 goal to increase the proportion of mothers who breastfeed by fifty percent. For 2011-2015 DC expects that within the WIC population breastfeeding persistence at 6 months will increase by ten percent fron 28.6 (2008) to 31 percent (2011).

Numerator: Breastfeeding rates for the District of Columbia's WIC population, are the percent of infant s who are being breastfed at 6 months of age. Data obtained from the Pregnancy Surveillance System (PNSS).

Denominator: Total women asked question.

Program emphasis is on the number of infants breastfed not the number of moms reporting breastfeeding. The information reported in PNSS is updated every 3 months when WIC checks are retrieved (that is, the woman must be participating in the program and not merely just be enrolled).

Notes - 2009
Source: 2009 DC Pediatric Nutrition Surveillance System (PedNSS). This data reflects:

Change in performance objective reflects the change in data source used to the calculate percent. 2008 goal was 42 and 2009 goal was 25.

Numerator: Breastfeeding rates for the District of Columbia's WIC population, are the percent of infant s wh0 are being breastfed at 6 months of age. Data obtained from the Pregnancy Surveillance System (PNSS).

Denominator: Total women asked question.

Emphasis on number of infants breastfed not the number of moms reporting breastfeeding. The information is updated every 3 months when checks are retrieved (that is, if participant is participating in the program and is not merely enrolled).

a. Last Year's Accomplishments
The CDC Breastfeeding Report Card (August 2011 and based on 2008 provisional births) reported that 48.6% of DC infants (US rate was 44.3% -- Healthy People 2020 goal is 60.6%) were breastfed at 6 months although only 17.1% were exclusively breastfed at that age. CDC also presented data on factors by state that contribute to breastfeeding. The United States has a very poor record of compliance with Baby Friendly hospital criteria and only 4.54% of births occurred in Baby Friendly-designated hospitals. None of the DC birthing hospitals were so designated until 2012 when MedStar/Georgetown University Hospital was awarded that designation (http://www.georgetownuniversityhospital.org/body.cfmid=15&UserAction=PressDetails&action=detail&ref=257),apparently after several years of effort by the DC Breastfeeding Coalition. Nearly 1/3 of DC infants received formula before 2 days of age, a practice not conducive to successful breastfeeding. (The Healthy People 2020 goal is 14.2%.) The District had 1 International Board Certified Lactation Consultant per 1,000 live births. Nor did the District fare well when child care center regulations that support lactation were considered: DC received a "not optimal" rating of 2 on a 4-point system.

Breastfeeding persistence at 6 months among the Women, Infants and Children (WIC) population increased by 20% from 20.2% in 2010 to 24.2% in 2011, nevertheless illustrating the great

disparity between the general population and low income, primarily African American WIC participants. CHA has responsibility for the WIC program. Efforts included:
1. Continued operating the Lactation Unit and Resource Center.
2. Continued the breastfeeding program through the WIC program that included a breastfeeding coordinator at the state level, and a lactation consultant and breastfeeding peer counselors at the local level. DOH hired a breastfeeding coordinator at the state level and 3 breastfeeding peer counselors at the local level.
3. Provided to eligible WIC participants breast pumps, education, and support, either one-on one, or as a group. DC WIC distributed 449 breast pumps to breastfeeding mothers who were returning to work or experiencing medical issues requiring the use of breast pumps.
4. Convened monthly "Beautiful Beginnings Club" breastfeeding support group meetings at 4 local agencies.
5. Continued collaboration with DC Breastfeeding Coalition to establish breastfeeding friendly hospitals.
6. Provided lactation training to Healthy Start nurses.
7. Provided the Certified Lactation Specialist training for 55 DC WIC staff and other partners in the community.
8. Initiated provision of 900 breastfeeding support bags to local birthing hospitals. This was done to encourage hospitals to replace their customary formula bags with breastfeeding support bags.
9. Distributed 100 breastfeeding support bags through the Healthy Start program

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue operating the Lactation Unit and Resource Center and continue to collect data on breastfeeding mothers.		X	X	
2. Continue WIC breastfeeding program	X	X	X	
3. Continue distribution to all eligible WIC participants of breast pumps, education, and support either one-on-one, or as a group.	X	X		
4. Continue to convene monthly "Beautiful Beginnings Club" breastfeeding support group meetings in the local agencies.			X	X
5. Continue to collaborate with DC Breastfeeding Coalition to establish breastfeeding friendly hospitals.			X	X
6. Continue to provide lactation training to new Healthy Start staff.		X	X	
7. Seeking to allot additional breastfeeding support bags for hospitals and other programs.			X	X
8. Partner with DCPS to provide breastfeeding education in high schools through the New Heights program.		X	X	
9.				
10.				

b. Current Activities
CHA staff:
1. Continue operating the Lactation Unit and Resource Center and continue to collect data on breastfeeding mothers.
2. Continue breastfeeding program through the WIC Program that includes a breastfeeding coordinator at the State level, and a lactation consultant and breastfeeding peer counselors at the Local level.
3. Continue distribution to all eligible WIC participants: breast pumps, education, and support either one-on-one, or as a group.
4. Continue to convene monthly "Beautiful Beginnings Club" breastfeeding support group meetings in the local agencies.

5. Continue to collaborate with DC Breastfeeding Coalition to establish breastfeeding friendly hospitals.
6. Continue to provide lactation training to new Healthy Start staff.
7. Seeking to allot additional breastfeeding support bags for hospitals and other programs.
8. Partner with DCPS to provide breastfeeding education in high schools through the New Heights program

c. Plan for the Coming Year
All efforts listed above will continue in 2013. In addition, WIC staff will increase breastfeeding support services for WIC mothers by increasing Breastfeeding Peer Counselor and/or International Board Certified Lactation Specialist services. Certified Lactation Specialist training for DC WIC staff and other breastfeeding partners in the community will be conducted.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	75	80	98	98	98
Annual Indicator	34.6	97.9	67.6	94.0	67.3
Numerator	5452	14199	10484	12960	9312
Denominator	15752	14500	15500	13788	13836
Data Source		AURIS	AURIS	AURIS	AURIS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	74	74	74	74	74

Notes - 2011
Information is provided by AURIS, a Welligent case management system. The percentage of newborns screened in 2011 shows a continued problem in retrieving data from DC birthing hospitals. In 2010 hospitals reported screening or 94% of the birth population. Because of the tri-state location of DC this is an acceptable response rate. The problem seems to be having hospitals to uniformly submit information into the AURIS system. In 2011, AURIS reports that 9,312 newborns were screened representing a rate of 67%. The 9,312 newborns generated 20,000 screening records indicating that that the system is generating an unacceptable number of duplicate records.

Notes - 2010
Information is provided by AURIS, a Welligent case management system. The percentage of newborns screened in 2010 shows a marked improvement compared to the numbers of newborns reported, but still well below acceptable levels. The surveillance system continues to generate duplicate records from activities at District birthing facilities. The 12,960 newborns screened in 2010 generated 24,627 individual records. In particular, of the total group screened, 164 newborns each generated 10 to 34 records each. This small group has far more records than would be expected, if newborn(s) are retested again for an abnormal result.

Notes - 2009
2009 newborn hearing data was obtained from the AURIS database system used by CHA. 15,149 screens were reported for 10,484 children with 2009 DOBs. The number of dulicate records ranged freom 1 - 36. Of this group 9,500 children had a single record, while 984 newborns had 5,649 records of screenings.

The tracking system continues to generate duplicate records as occurred last year.

a. Last Year's Accomplishments
The percentage of newborns screened in 2011 indicates a continuing problem in receiving data from DC birthing hospitals. In 2010 hospitals reported screening 94% of the birth population. Rates have fluctuated wildly since 2007, probably due in part to problems with data quality and variability in reporting. The problem seems to have to do with hospitals' staffs not using uniform procedures in submitting information into the AURIS system. In 2011, AURIS reported that 9,312 newborns were screened representing a rate of 67%. Problems with data quality have been observed for many years.

During the year it became evident that hospitals needed to replace their hearing screening equipment. Infants were not being screened consistently and false negatives were being reported. Hospitals requested that DOH-Title V purchase new equipment for their use. Program managers determined that such assistance to hospitals was not feasible.

The PIHB:
1. Provided referral services and follow up for infants with positive hearing screening.
3. Continued to explore possibilities with OSSE to improve follow up with children with positive hearing results.
4. Continued to provide literature to parents whose child did not have a hearing screening.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Hospitals and birthing centers asked to replace current hearing screening equipment to improve referral process.	X		X	
2. Working to increase data verification of screenings				X
3. Continue to collaborate with OSSE to ensure follow-up of positive screens.	X			
4. Continuing to distribute new brochures to hospitals containing information for parents. about failed initial hearing screening, including a translation of DC Hears into Spanish.	X		X	
5. Increasing the integration with the medical home by identifying the pediatrician or Primary Care Provider prior to discharge.			X	X
6. Ensuring appropriate developmental progress for children with hearing loss through collaboration with providers and parents.	X		X	
7. Working to increase parents" and childcare providers' knowledge of hearing screening and appropriate developmental progress for children with hearing loss through collaboration with providers and parents.	X		X	
8. Coordinating care by partnering with the Infants and Toddlers with Disability Division (ITDD).	X		X	X
9. Co-managing, in collaboration with ITDD and the Special Education units at DCPS and OSSE, children 0 to 3 years of age referred with hearing loss.	X	X		

10. Providing hospitals with a new MIS that will correct problems with AURIS, thereby improving improve hearing screening reporting, follow-up and tracking.				X

b. Current Activities

1. Six of 8 hospitals and birthing centers have replaced their hearing screening equipment.
2. Working to increase data verification of screenings by partnering with Vital Records.
3. Continuing to collaborate with OSSE to ensure timely follow-up of infants referred with positive hearing screens.
4. Continuing to distribute new brochures to hospitals containing information for parents. about failed initial hearing screening, including a translation of DC Hears into Spanish.
5. Increasing the integration with the medical home by identifying the pediatrician or other primary care provider prior to discharge.
6. Ensuring appropriate developmental progress for children with hearing loss through collaboration with providers and parents.
7. Working to increase parents' and childcare providers' knowledge of hearing screening.
8. Coordinating care by partnering with the Infants and Toddlers with Disability Division (ITDD).
9. Co-managing, in collaboration with ITDD and the Special Education units at DCPS and OSSE, children 0 to 3 years of age referred with hearing loss.
10. Providing hospitals with a new information system that will correct problems with AURIS, thereby improving improve hearing screening reporting, follow-up and tracking.

c. Plan for the Coming Year

1. Install new hearing tracking information software in hospitals; train and monitor staff. Establish procedures for improving reporting and data quality.
2. Increase parents and 'childcare providers' knowledge through education on developmental milestones.
3. Engage an audiologist to conduct training sessions for parents and early child care providers regarding age-appropriate milestones for speech and language development.
4. Increase coordination of care by partnering with the Infants and Toddlers with Disability Division (ITDD).
5. Continue collaboration with ITDD and the Special Education units at DCPS and OSSE, will continue to monitor and co-manage children 0 to 3 years of age referred with hearing loss.
6. Continue to collaborate with OSSE to improve follow-up timeframe for infants with a hearing loss.
7. Continue medical home integration project for children with special needs: referral services and follow-up for infants with positive hearing screening.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	6	6	6	6	7
Annual Indicator	7.8	8.0	7.6	7.9	7.9
Numerator	9221	9090	8700	8000	8000
Denominator	118104	113720	114036	100815	100815
Data Source		State Health	State Health	State Health	State Health Facts and

		Facts and Census data	Facts and Census data	Facts and Census data	Census data
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	7	6	6	6	6

Notes - 2011
The 2010 data is used here until the 2011 data becomes available. The 2010 data is used here.
Numerator: 2010 District of Columbia: Health Insurance Coverage of Children 0-18, states (2009-2010) U.S. (2010)
http://www.statehealthfacts.org/ Accessed: May 15, 2012

Denominator: The Untied States Census Bureau, Source: US Census Bureau, Population Estimates Program

District of Columbia
T8-2009. Sex and Selected Age Groups [QT-P1]
Data Set: 2010 Population Estimates

Notes - 2010
The 2010 data is used here. Numerator: 2010 District of Columbia: Health Insurance Coverage of Children 0-18, states (2009-2010) U.S. (2010)
http://www.statehealthfacts.org/ Accessed: May 15, 2012

Denominator: The Untied States Census Bureau, Source: US Census Bureau, Population Estimates Program

District of Columbia
T8-2009. Sex and Selected Age Groups [QT-P1]
Data Set: 2010 Population Estimates

Notes - 2009
Numerator: 2009 District of Columbia: Health Insurance Coverage of Children 0-18, states (2008-2009) U.S. (2009)
http://www.statehealthfacts.org/profileglance.jsp?rgn=10
Date Accessed: May 2, 2011

Denominator: The Untied States Census Bureau, Source: US Census Bureau, Population Estimates Program

District of Columbia
T8-2009. Sex and Selected Age Groups [15]

Data Set: 2009 Population Estimates
http://factfinder.census.gov/servlet/DTTable?_bm=y&-context=dt&-ds_name=PEP_2009_EST&-mt_name=PEP_2009_EST_G2009_T008_2009&-mt_name=PEP_2009_EST_G2009_T001&-CONTEXT=dt&-tree_id=809&-all_geo_types=N&-geo_id=04000US11&-search_results=01000US&-format=&-_lang=en

Date Accessed: May 2, 2011

a. Last Year's Accomplishments
Between 2009 and 2010, the percent of children without health insurance coverage increased by 4%, from 7.6% in 2009 to 7.9% in 2010. (Confidence intervals were not reported.) This rate has been relatively stable over the past years. Numerous public agencies as well as hospitals and community health centers make every effort to enroll eligible children in the Medicaid-SCHIP program.
CHA:
1. Continued the Healthy Start, MOM unit and other outreach programs to enroll eligible pregnant and parenting women and their children in insurance and other entitlement programs.
2. Expanded collaboration with DC Jail and shelters to inform parents of public insurance for children.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Working with DHCF to maintain edibility level for Medicaid/CHIP children at 300% Federal Poverty level.	X			X
2. Encourage DHCF to attend Health Fairs and Community Events to enroll children and their families into the District's Medicaid Program. Continued outreach will occur by DHCF's enrollment broker and managed care organizations.	X		X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The District Medicaid-SCHIP program maintained eligibility for children at 300% Federal Poverty Level. DHCF continues to participate in health fairs, street festivals and other community events to inform families of public health insurance programs. The contracted enrollment broker and the managed care organizations also conduct outreach.

c. Plan for the Coming Year
The activities mentioned above will continue. Also, CHA will request technical assistance to create a plan with DHCF on implementing the TEFRA/Katy Beckett eligibility pathway.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	13	12	12	12	26
Annual Indicator	14.6	33.6	28.6	28.6	27.4
Numerator	791	1820	1928	1989	1911
Denominator	5419	5419	6742	6954	6978
Data Source		DC PedNSS 2008	DC PedNSS 2009	DC PedNSS 2010	DC PedNSS 2011
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	26	26	26	26	26

Notes - 2011
The mission of the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) includes providing nutritious food supplements and nutrition education for women, infants, and children.
One of the most worrisome aspects of the growing tide of obesity in the United States is the high rate of overweight among children. Over one in five young children, ages 2 to 5, are at risk of being overweight, as measured using their Body-Mass-Index-for-age is at or above the 85th percentile.
District of Columbia rates are hovering at 28 percent- higher than the national average.

The District of Columbia's 2011-2015 Annual performance measures were modeled similar to Healthy People 2020's objectives. The performance measures are predicted to improve by 10 percent to be achieved by 2015.

Source: District of Columbia PedNSS 2009.

Numerator information: 1,911

Denominator: All children in WIC between ages 2 to 5 years.

Notes - 2010
The mission of the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) includes providing nutritious food supplements and nutrition education for women, infants, and children.
One of the most worrisome aspects of the growing tide of obesity in the United States is the high rate of overweight among children. Over one in five young children, ages 2 to 5, are at risk of being overweight, as measured using their Body-Mass-Index-for-age is at or above the 85th

percentile.
District of Columbia rates are hovering at 28 percent- higher than the national average.
The District of Columbia's 2011-2015 Annual performance measures were modeled similar to Healthy People 2020's objectives. The performance measures are predicted to improve by 10 percent to be achieved by 2015.

Source: District of Columbia PedNSS 2009.

Numerator information:
Information broken down into two groups:
Percentile
=>85th to <95th >95th >=85th Percentile

1,036 (14.9%) + 953 (13.7%) = 1,989 (total)

Denominator: All children in WIC between ages 2 to 5 years.

Notes - 2009
Source: District of Columbia PedNSS 2009.

Numerator information:
Information broken down into two groups:
Percentile
=>85th to <95th >95th >=85th Percentile

1,011 + 917 = 1,928 (total)

Denominator: All children in WIC between ages 2 to 5 years.

a. Last Year's Accomplishments
Among the Women, Infants and Children population, the percentage of children aged 2 to 5 years with a body mass index at or above the 85th percentile decreased by 4% from 28.6 in 2009 to 27.4 in 2010. This decrease represents a declining trend from 2008, when 33.6% of this population was at or the 85th percentile.
Activities undertaken included:
1. DC WIC hired a breastfeeding coordinator.
2. DC WIC provided the Certified Lactation Specialist training for 55 DC WIC staff and other breastfeeding partners in the community.
3. Worked with local advocates and market managers and trained 13 additional farmers to participate in the District's Farmers' Market Nutrition Program. There were 55 farmers in total in 2011 participating in the FMNP.
4. Continued to promote the physical activity component of the program in clinics, schools, and community sites through SNAP-ED, WIC, and CSFP participant nutrition education lesson plans.
5. Participated in the Citywide Pediatric Forum defining goals for future activities: To create a district-wide anti-child obesity initiative based on the AAP goal to increase time children and youth spend outdoors by working with the medical pediatric community.
6. Participated in a city-wide partnership with National Park Service, Unity Health Care and Children's National Medical Center to develop DC Park Prescription Initiative, a program for pediatricians to prescribe time in parks for overweight, obese and children suffering from ADHD as an effective intervention.
7. Developed a standardized assessment tool for all greenspaces in DC.
See also activities under performance measure 11.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Adding additional breastfeeding support bags for hospitals and other programs.	X	X	X	
2. Continue to provide WIC nutritional services and promote healthier eating lifestyles.	X		X	
3. Continue to refine the obesity action plan.	X		X	
4. Continue to promote the physical activity in clinics, schools, and community sites through SNAP-ED, WIC, and nutrition education lesson plans.	X		X	
5. Provide breastfeeding education in high schools through the New Heights program.	X		X	
6. Attempting to hire a new WIC nutritionist to fill a critical gap in staffing. Hired 3 additional breastfeeding peer counselors.				X
7. DC Park Prescription pilot program NW and SE. Assessing Parks.		X	X	
8. Continue to issue electric and manual breast pumps to breastfeeding mothers who are returning to work or experiencing medical issues requiring the use of breast pumps.	X		X	
9. Train farmers to participate in the District's Farmers' Market Nutrition Program.		X	X	
10. Pilot food cart program		X	X	

b. Current Activities

1. Seeking to allot additional breastfeeding support bags for hospitals and other programs.
2. Continuing to provide WIC nutritional services and promote healthier eating lifestyles
3. Continuing to refine the obesity action plan.
4. Continuing to promote the physical activity component of the program in clinics, schools, and community sites through SNAP-ED, WIC, and CSFP participant nutrition education lesson plans.
5. Providing breastfeeding education in high schools through the New Heights program.
6. Attempting to hire a new WIC nutritionist to fill a critical gap in staffing. The new nutritionist would focus on training local agency nutritionists to improve services in DC WIC.
7. Coordinating with the American Academy of Pediatrics (AAP) Park Prescription Program.
8. Assessing parks, 25% assessed to date with all to be completed by August 2012 for kick off in September.
9. Continuing to issue electric and manual breast pumps to breastfeeding mothers who are returning to work.
10. Worked with local advocates and market managers and trained 11 additional farmers to participate in the District's Farmers' Market Nutrition Program. There are 46 total farmers in 2012.
11. Released an RFP for a CBO to operate a food cart in areas considered food deserts.

See also activities under performance measure 11.

c. Plan for the Coming Year

1. Increase breastfeeding support services for WIC mothers by increasing Breastfeeding Peer Counselor and/or International Board Certified Lactation Specialist services.
2. Continue to promote the physical activity component of the program in clinics, schools, and community sites through SNAP-ED, WIC, and CSFP participant nutrition education lesson plans.
3. Continue to partner with DCPS to provide breastfeeding education in high schools through the

New Heights program.
4. Provide through WIC the Certified Lactation Specialist training for additional DC WIC staff and other breastfeeding partners in the community.
See also activities under performance measure 11.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					5
Annual Indicator			6.9	0.3	0.3
Numerator			427	17	17
Denominator			6154	6318	6318
Data Source			DC 2009 Birth File	SCHS 2010 Birth File	SCHS 2010 Birth file
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	1	1	1	1	1

Notes - 2011
The District of Columbia has a 2-year delay for reporting Birth data. Currently 2010 birth data is used to populate information for 2011. When the data becomes available this measure will be updated.
Data: SCHS 2010 Birthfile

Notes - 2010
Out of the 6318 mothers where prenatal care information was captured, only 17 self reported smoking in their third trimester.
Data: SCHS 2010 Birthfile

Notes - 2009
Currently the District of Columbia Birth Certificate does not collect smoking data per trimester of pregnancy. The pilot for the implementation of the 2003 Birth Certificate started in January of 2009 and full implementation is now in effect as of the end of March 2009. In the future the District will have the capacity to collect and report on smoking by trimester.

a. Last Year's Accomplishments
The percentage of women who self report smoking during their last three months of pregnancy was 0.3% in 2010 compared to 6.9% in 2009. CHA activities included;
1. Provided counseling to pregnant and parenting women on health effects of cigarette smoking (Healthy Start case managers and family support workers).
2. Worked with community agencies, United Medical Center, Breathe DC and APRA in support of

smoking cessation.
3. Worked with Vital Records to update forms to accurately capture smoking data in accordance with adoption of the U.S. Standard Certificate of Live Birth.
5. Provided referrals to smoking cessation through the 800 information number
6. Operated the smoking quit line
7. Included tobacco use prevention education in school health education programs, school-based health centers, and medical home projects

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue counseling pregnant and parenting women on health effects of cigarette smoking.	X	X	X	
2. Continue to work with community agencies, Breath DC and APRA in support of smoking cessation.	X		X	X
3. Continued to provide referrals for smoking cessation.		X	X	X
4. Continue the 1-800 smoking quit line.		X	X	
5. Launched the I Care About Me campaign.		X	X	
6. Continue prevention education in the schools.		X	X	
7.				
8.				
9.				
10.				

b. Current Activities
1. Continue to counsel pregnant and parenting women on health effects of cigarette smoking through Healthy Start and the school nurse program.
2. Continue to work with community agencies, Breath DC and APRA in support of smoking cessation resources.
3. Continue to provide referrals to smoking cessation through the 800 information number
4. Continue the smoking quit line. The CHA Tobacco Program analyzed the calls to the Tobacco Quit Line (January 2010 -- March 2012) and found that 7,148 callers registered, enrolled in counseling (IR = Intervention Requested) or were sent materials (MO = Materials Only). Of the 3,854 female callers, 50 were pregnant. If funding allows in the next year, emphasis will be placed on increasing educational efforts to women, especially pregnant women.
5. Launched "I Care About Me", a public awareness campaign using social and traditional media to reinforce healthy behaviors among teens and youth.
6. Continue tobacco use prevention education in school health education programs, school-based health centers, and medical home projects.

c. Plan for the Coming Year
Continue all current activities.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011

Annual Performance Objective	5	5	3	3	2.1
Annual Indicator	2.5	2.3			
Numerator	1	1			
Denominator	40355	44114	44385	39890	39890
Data Source		DC 2008 Death Data (Vital Statisitcs)	DC 2009 Death File	DC 2010 Death File	2010 Death File
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	Yes
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	2.1	2.1	2	2	2

Notes - 2011
The District of Columbia has a 2-year delay for reporting death data. Data for 2010 will be reported here and updated next year.

Since there was less than 5 events last year we could not report the numerator. And therefore this year is blank as well..

Source Denominator: United States Census Bureau 2010 American Fact Finder Population: Youths aged 15-19. - 39,890.

Notes - 2010
The District of Columbia has a 2-year delay for reporting death data. Data for 2010 will be reported here and updated next year.

There is less than 5 events, and therefore we cannot report the numerator.

Source Denominator: United States Census Bureau 2010 American Fact Finder Population: Youths aged 15-19. (n=39,890)

Notes - 2009
Source Numerator: The District of Columbia State Center for Health Statistics 2009 Death file. There is less than 5 events, and we cannot report the numerator.

Source Denominator: United States Census Bureau 2009 American Fact Finder Population Estimates for the District of Columbia

a. Last Year's Accomplishments
Deaths due to suicide among youths aged 15-19 continue to occur rarely. DC and Healthy People objectives have been met.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. Collaborate with the District of Columbia Public and Charter Schools, Department of Mental Health, and APRA to identify and collect data on youth who have attempted suicide strategies for tracking the rates of youth suicide deaths.			X	X
2. Launched the I Care About Me campaign.		X	X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CHA is collaborating with the District of Columbia Public and Charter Schools, Department of Mental Health, APRA and community partners to identify and collect data on youth who have attempted suicide. CHA launched "I Care About Me" public awareness campaign directed toward teens and youth.

c. Plan for the Coming Year

1. Develop a state-wide public education campaign to help the general public, parents of youth, youth in the work force, and youth not working or in school to:
- become aware of the increasing problem of youth suicide and suicidal behaviors;
- recognize common warning signs of suicidal thoughts and intent;
- learn how to respond to youth who exhibit these signs;
- know when and where to go for accurate assessments and professional help.

2. Work with District of Columbia Public and Charter Schools to develop a school-based education campaign in all high schools to teach young people the warning signs of suicidal intent, and how to respond to and get help for friends who exhibit these signs.
3. Work with the Department of Mental Health and LGBT advocacy groups to develop strategies to alleviate pressures experienced by LGBT teens.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	80	80	80	80	80
Annual Indicator	76.0	76.1	79.7	90.5	90.5
Numerator	196	178	153	191	191
Denominator	258	234	192	211	211
Data Source		2008 DC Birth File	2009 DC birth File	2010 SCHS Birth File	2010 SCHS birth file
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over					

the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	95	95	95	95	95

Notes - 2011
The District of Columbia has a delay for reporting Birth data this year. Currently 2010 birth data is used to populate information 2011. When the data becomes available this measure will be updated.

Notes - 2010
Between 2009 and 2010 the percent of very low birth weight (VLBW) (less than 1,500g) infants increased by nearly 14 percent. For the past three years more VLBW deliveries are occurring in in Level III or IV facilities in the District with Washington Hospital Canter leading the District in VLBW births

Source: SCHS DC 2010 Birth file. Out of the 211 VLBW births, 191 infants were delivered in level III or IV hospitals.

Notes - 2009
Data obtained from the 2009 SCHS Birth File.

a. Last Year's Accomplishments
Although between 2009 and 2010 the percent of very low birth weight (VLBW) (less than 1,500g) infants increased by nearly 14% from 2.1% to 2.3%. The proportion of VLBW deliveries in Level III or IV facilities increased to 90.5% in 2010. The 2010 objective was exceeded. The largest number of VLBW births occurred in the Washington Hospital Center.

Activities included:
1. Continued to promote the "I am a Healthy DC Mom" public awareness campaign.
2. Monitored and guided the sub-grantees of the Parent Information Network grant to make resources available on various conditions including the risks of low birth weight.
4. Provided case management for Healthy Start, high risk participants, including planning for place of delivery.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Monitoring, Evaluating and guiding the Parent Information Network vendor.	X			X
2. Continue promoting the "I am a Healthy DC Mom" public awareness campaign.	X	X	X	
3. Continuing the Healthy Start Program	X		X	
4. Launching the "I Care About Me" public awareness campaign.		X	X	
5.				
6.				
7.				
8.				
9.				

10.				

b. Current Activities
CHA is:
1. Monitoring, evaluating and guiding the Parent Information Network vendor.
2. Promoting the "I am a Healthy DC Mom" public awareness campaign.
3. Continuing the Healthy Start program.
4. Launching the "I Care About Me" pubic awareness campaign.

c. Plan for the Coming Year
CHA intends to:
1. Award a sub-grant to continue a Parent Information Network.
2. Coordinate with medical societies to inform and educate providers on recommendations for the use of alcohol during pregnancy and on fetal alcohol spectrum disorders.
3. Continue collaboration with APRA to support treatment and recovery for pregnant women to mitigate the likelihood of low or very low birth weight babies due to exposure to drugs, alcohol, and cigarettes during pregnancy.
4. Continue collaborations to identify mothers who need WIC services in order to support mothers of lower socioeconomic status that are more likely to have poorer pregnancy nutrition, inadequate prenatal care, and pregnancy complications.
5. Continue to promote the "I am a Healthy DC MOM" and "I Care About Me" public awareness campaigns.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	78	78	80	80	82
Annual Indicator	73.0	74.7	74.7	70.0	70.0
Numerator	5642	6103	6103	4420	4420
Denominator	7731	8172	8172	6318	6318
Data Source		2008 DC Birth File	2008 DC birth File	2010 SCHS Birth File	2010 SCHS Birthf ile
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	73.5	73.5	73.5	73.5	73.5

Notes - 2011

The District experiences a 2-year delay in vital statistics reporting. For this measure, 2010 data is used. When the 2011 data becomes available, this measure will be updated.

Notes - 2010
The percent of women who initiate prenatal care has hovered at seventy percent or higher since 2000. However, within the last two years (2009-2010), the percent of women entering prenatal care has declined by six percent. To reach pregnant and women who are thinking about becoming pregnant, the District has developed; I am a Healthy DC Mom, and the First Time Motherhood social marketing campaigns. The campaign themes focus on stressing on the importance of PNC care, developing and maintaining healthy lifestyles, and delaying a repeat pregnancy within 24 months of a prior pregnancy (interconceptual period.). The Perinatal and Infant Health Bureau's (PIHB) Healthy Start program since its inception in 1996, aim is to reduce perinatal outcome disparities (including infant mortality, very low and low birth weight, and preterm birth) and to improve the preconception/interconception health status of women residing in Wards 5, 6, 7 and 8 of the District. Wards 5,6,7, and 8 are targeted because health disparities, and poverty are the greatest in these District wards.

Only 6,618 live births captured prenatal care information on the birth certificate, (although there were 9156 live births to District residents (this number is used as the denominator and the numerator is the number of women (n= 4220) who began prenatal care in the first trimester. Source: District of Columba SCHS 2010 birth file.

Notes - 2009
Data for 2008 is reported here until 2009 information can be obtained. This is due to a change in migrating from the onld NCHS birth certificate to the new 2003 format. This information is expected to be revised when the final 2009 birth file is obtained.

However, the District expects a ten percent increase in the percent of pregnant women receiving prenatal care in the first trimester from 74.7 percent in 2008 to approximately 82 percent by 2015 and this is reflected in the Annual Performance Measures for 2011-2015.

a. Last Year's Accomplishments
The percent of women who initiate early prenatal care has hovered at 70% or higher since 2000. However, within the last two years (2008-2010), the percent of women entering prenatal care in the first trimester has declined by 6%.

To reach pregnant and women who are thinking about becoming pregnant, the District developed "I am a Healthy DC Mom" and the' First Time Motherhood" public awareness campaigns. The campaign themes focus on the importance of prenatal care (PNC) care, developing and maintaining healthy lifestyles, and delaying a repeat pregnancy within 24 months of a prior pregnancy (interconceptual period.). Since the Healthy Start program's inception in 1991, its aim has been to reduce perinatal outcome disparities (including infant mortality, very low and low birth weight, and preterm birth) and to improve the preconception/interconception health status of women residing in Wards 5, 6, 7 and 8 of the District. Wards 5,6,7, and 8 are targeted because of the high prevalence of poverty and health disparities in these District wards. Staff engages in outreach in low income neighborhoods to identify pregnant women and to assist them in obtaining medical care. Women are enrolled in case management and followed through delivery and the inter-conception period.

CHA:
1. Continued the "I am a Healthy DC Baby" public awareness campaign.
2. Continued to increase oversight and effectiveness of the Healthy Start program's nurse case management component.
3. Expanded recruitment, training and deployment of new family support workers under the Healthy Start program to provide complementary support services that address psycho-social risk factors affecting pregnant and parenting women and their children.

4. Continued to promote "I am a Healthy DC Mom" public awareness campaign.
5. Collaborated with DC Jail and shelters to increase early identification of pregnancy and ensure timely enrollment in PNC under Medicaid and the DC HealthCare Alliance.
6. Developed and launched "I am a Healthy DC Dad" public awareness campaign.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue the "I am a Healthy DC Dad" public awareness campaign to educate fathers and perspective fathers	X		X	
2. Continuing "I Am a Healthy DC Baby" and "I Am a Healthy DC Mom" public awareness campaigns.	X		X	
3. Continuing the Healthy Start program's nurse case management and family support worker services to encourage early and consistent prenatal care.	X		X	
4. Continuing to assist with enrollment of pregnant women in Medicaid and the DC Health Care Alliance.		X	X	
5. Continuing efforts with HAHSTA to promote routine prenatal HIV testing and treatment that prevents perinatal HIV transmission to the infant.	X	X	X	
6. Enhancing linkage to mental health and substance abuse education and treatment.	X		X	
7.				
8.				
9.				
10.				

b. Current Activities
CHA is:
1. Continuing the "I am a Healthy DC Dad" public awareness campaign to educate fathers and prospective fathers on the importance of their role in improving perinatal disparities.
2. Continuing "I Am a Healthy DC Baby" and "I Am a Healthy DC Mom" public awareness campaigns.
3. Continuing the Healthy Start program's nurse case management and family support worker services to encourage early and consistent prenatal care
4. Continuing to assist with enrollment of pregnant women in Medicaid and the DC Health Care Alliance.
5. Continuing efforts with HAHSTA to promote routine prenatal HIV testing and treatment that prevents perinatal HIV transmission to the infant. Over the past 10 years the number of pediatric cases diagnosed in the District has declined and there were no cases reported during 2010 (DC DOH HAHSTA 2011 Annual Report, June 2012).
6. Enhancing linkage to mental health and substance abuse education and treatment.

c. Plan for the Coming Year
CHA intends to:
1. Hold an Annual Baby Shower event in May for pregnant women
2. Continue "I Am a Healthy DC Mom", "I Am a Healthy DC Baby" and "I am a Health DC Dad" public information campaigns.
3. Continue the Healthy Start project and the early identification of pregnancy and enrollment in

prenatal care for pregnant under Medicaid and the DC Health Care Alliance.
4. Continue to collaborate with HAHSTA to ensure routine prenatal HIV testing and treatment.
5. Continue to collaborate with DMH and APRA to refer pregnant women and families to mental health and substance abuse education and treatment services, and to ensure prenatal care is included in residential and other services.
6. Continue to collaborate with shelters to facilitate outreach and linkages to care for homeless pregnant women.
7. Continue education on and provision of contraception services at community health centers.

D. State Performance Measures

State Performance Measure 1: *Prevalence of tobacco use among pregant women.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective				3	3
Annual Indicator			6.5	3.5	3.5
Numerator			427	295	295
Denominator			6581	8429	8429
Data Source			DC 2009 Birth File	DC 2010 Birth File	DC 2010 Birth File
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	3	3	3	3	3

Notes - 2011
The District of Columbia has a delay for reporting birth data this year. Currently 2010 birth data is used to populate information for 2010 and 2011. When the data becomes available- this measure will be updated.

Notes - 2010
Within the last two years the prevalence of tobacco use among pregnant women has declined by forty-six percent. Smoking data is self reported. Out of the 9,156 live births - only 8429 responded with a 'yes' or 'no' about smoking during their pregnancy. This number was used as the denominator (n=8429) and the numerator was (n=295) the number of women who responded "yes" to smoking during their pregnancy. (A total of 727 women where information was recorded as: "unknown").

Source: District of Columbia State Center for Health Statistics 2010 Birth file.

Notes - 2009
Note: This data is self-reported and underreporting may have occurred.

a. Last Year's Accomplishments
Smoking data is self reported. Out of the 9,156 live births in 2010, 8429 women responded with a 'yes' or 'no' about smoking during their pregnancy. This number was used as the denominator (n=8429) and the numerator is (n=295) the number of women who responded "yes" to smoking during their pregnancy. (For a total of 727 women, the information was recorded as: "unknown"). Interestingly, considerably fewer (6318) women responded to the question (performance measure 15) about smoking in the third trimester. Within the last two years the prevalence of reported tobacco use among pregnant women has declined by 46%. This data is self-reported on the birth

certificate and under reporting may have occurred. However, it would seem unlikely that under-reporting would explain such a considerable change over that period.

CHA activities were the following:
1. DC Healthy Start case managers continued education of pregnant women and new mothers on the adverse health effects of direct and second hand tobacco exposure to themselves and their children.
2. The DOH initiated public service announcements on the hazards of second and third hand tobacco exposure.
3. I am a Healthy DC Mom was used to educate women on health hazards of tobacco usage and healthy methods of stress relief
3. Pregnant women were connected to available tobacco cessation help resources via the 800 information number and the quit line.

See national performance measure 15

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Healthy Start Case Management	X	X	X	
2. Electronic birth certificate			X	X
3. Continue the I am a healthy DC MOM and I am a Healthy DC Dad public awareness campaigns	X	X	X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The DC Healthy Start program continues to collect data from enrolled pregnant and postpartum women on tobacco use and refers them to resources available to help with smoking cessation including private providers and school-based health centers.
Continue the I Am a Healthy DC MOM, I Am a Healthy DC DAD campaigns as well as introduce I Care About Me campaign.
See national performance measure 15.

c. Plan for the Coming Year
See nationlal performance measure 15.

CHA intends to assess and continue the I Care About Me public awareness campaign to promote pre-conceptional health (including non-smoking) for teens and youth "who have yet to conceive".

State Performance Measure 2: *Percent of resident women who give birth with no prenatal care or no early entry into prenatal care by the 3rd trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective				5	5.2
Annual Indicator			5.8	6.4	6.4
Numerator			475	403	403
Denominator			8160	6318	6318
Data Source			DC 2008 Birth File	DC 2010 Birth File	DC 2010 Birth File
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	5.2	5.2	5.2	5.2	5.2

Notes - 2011
The District of Columbia experiences a 2-year delay for reporting birth data. For this measure, 2010 data is used here. When the 2011 birth file becomes available, this mesaure will be updated.

Notes - 2010
Based on the available data, the District vital statistics file, the number of visits is not captured on the birth certificate. However, the number of women who initiated care by trimester is calculated- and is used here to populate this measure. In addition, only 6,618 live births captured this information on the birth certificate, (although there were 9156 live births to District residents (this number is used as the denominator and the numerator is the number of women who began prenatal care in the first trimester.
Out of 9,156 births, only 6318 mothers self reported this measure. A total of 403 mothers y entered into prenatal care in the third trimester.
Source: District of Columbia SCHS 2010 Birth File

Notes - 2009
The Department of Health's Healthy Start program continues to promote prenatal care through the Healthy Program. The Healthy Start program works in some of the District's most underserved communities in Wards 5,6 7 and 8. Emphasis is placed on encouraging pregnant women to enter into prenatal care in the first trimester, and providing referrals to health and social service programs.

Data for 2008 is reported here until 2009 information can be obtained. This is due to a change in migrating from the onld NCHS birth certificate to the new 2003 format. This information is expected to be revised when the final 2009 birth file is obtained.

Out of 9,135 births, only 8,160 mothers self reported this measure. A total of 974 mothers did not report when they entered into prenatal care.

a. Last Year's Accomplishments
Trimester of entry into care was collected on birth certificates for only 6,618 of the 9156 live births to District residents in 2010. A total of 403 infants were delivered to women who entered into prenatal care in the third trimester or reported having no care at. Within the last 10 years, (2001-2010) the percent of women entering into prenatal care very late or not at all averaged 7%, ranging from 5.8% in 2009 to 8.3% in 2002. Although this percentage remains low, between 2009 and 2010, the percent of women with very late or no care increased from 5.8 to 6.4%, an increase of 10%. DC Healthy Start's (DCHS) Outreach and Case Management component continued to refer eligible pregnant women into prenatal care, health insurance and entitlement programs. DCHS also collaborated with the Department of Corrections (DOC) and Coalition for the Homeless to identify and assist pregnant women with access to prenatal care, health insurance and entitlements.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MOM mobile continues outreach and case management services	X	X	X	
2. Healthy Start continues collaoration with Department of Correction and the shelters to educate women about prenatal care	X	X	X	
3. Collaborated with community partners to increase identification of women early in their pregnancies	X	X	X	
4. Continue to connect uninsured with Medicaid or other Managed Care Organizations	X	X	X	
5. Facilitate outreach and linkages to care for homeless pregnant women.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
DCHS's Outreach, Case Management and Maternity Outreach Mobile (MOM) continues to identify and refer eligible pregnant women into prenatal care, insurance and entitlement programs and to follow up with home visits. DCHS continues to collaborate with DOC and Coalition for the Homeless. DCHS also continues its collaborations with two senior high schools to identify and assist pregnant women and teens with access to prenatal care, insurance and entitlement programs.

c. Plan for the Coming Year
The activities listed above will continue.

State Performance Measure 3: *Incidence of repeat teen births among girls less than 19 years of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective				18.5	10.8
Annual Indicator			12.3	16.1	16.1
Numerator			85	97	97
Denominator			690	603	603
Data Source			DC 2009 Birth File	DC 2010 Birth File	DC 2010 Birth File
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	10.8	10.8	10.8	10.8	10.8

Notes - 2011

The District has a 2-year delay in reporting birth data. 2010 birth data is used until the 2011 becomes available.

Notes - 2010
The incidence of repeat teen births for teen less than 19 years of age increased from 12.3 in 2009 to 16.1 in 2010. Within the past ten years (2001-2010) teens less than 19 years of age- having a repeat birth has decreased from 18.4 percent in 2001, dropping to a historic low of 12 percent in 2008, but increased to 16.1 percent in 2010. Although, the repeat teen pregnancy rate fluctuates from year to year, it is trending downwards, and the District continues to strive to meet its Title V Objective of reducing the incidence of repeat teen births to 10.8 percent. This District intends to continue to partner with its Healthy Start Program and other programs who are working with the District's teen population to delay repeat teen pregnancies, by providing comprehensive health care, access to contraceptive methods, and social support services.

Source: DC SCHS 2010 Birth File.

Notes - 2009
The District continues to anticipate a downward trend of repeat teen births for teens less than 19 years of age. By 2015 the District anticipates a ten percent decline from 12.0 percent in 2008 to approximately 10.8 percent by 2015.

.

a. Last Year's Accomplishments
In 2010 of the 603 infants born to women under 19 years of age, 16.1% were repeat teen births, compared to 12.3% in 2009. Within the past 10 years (2001-2010), the percent of births to teens that were repeat births ranged from 12% in 2008 to 18.4% in 2001. Although the repeat teen pregnancy rate fluctuates from year to year, it appears to be trending downwards, and the District continues to strive to meet its Title V objective of reducing the incidence of repeat teen births to 10.8%.

CHA efforts included the following:
• PIHB continued collaboration with school nurses to provide health education in DCPS.
• PIHB collaborated with community partners to increase identification of women early in their pregnancies and ensure timely enrollment into prenatal care using the services of DC Healthy Start outreach and case management staff. Case managers work to ensure that post-delivery clients receive counseling, information and prescriptions for contraception.
• Staff continued to refer students for reproductive health care and other services at the existing and expanded school-based health center sites.

See national performance measure 08.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. PIHB continued collaboration with School Nurses to provide health education in DCPS.	X	X	X	
2. Continue to support increased well-child pediatric visits.				
3. Expanded school-based health center sites.	X	X	X	
4. Enhance community-based screening and prevention services for at-risk youth and families served by the child protective service agency (CFSA).			X	
5. Continue to refer students for reproductive health care and			X	

other services				
6. Continued screening all enrolled healthy start women and their children at risk for mental illness, and multiple pregnancies.	X			
7.				
8.				
9.				
10.				

b. Current Activities
PIHB continued collaboration with school nurses to provide health education in DCPS. School nurses continue to refer students for reproductive health care and other services at the existing and expanded school-based health center sites and to community health centers.

See national performance measure 08.

c. Plan for the Coming Year
CHA intends to:
1. Continue to provide comprehensive health, adolescent wellness and sexuality education programs through DCPS.
2. Continue collaborative efforts with the Office of Youth Engagement to link pregnant and parenting teens enrolled in school based teen pregnancy programs with DCHS home visitation services.
3. Enhance linkages and improve referral processes for substance abuse treatment services.
See national performance measure 08.

State Performance Measure 4: *Percent of preterm births.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective				10.5	11
Annual Indicator			11.0	11.6	11.6
Numerator			983	945	945
Denominator			8925	8172	8172
Data Source			DC 2009 Birth File	DC 2010 birth file	DC 2010 birth file
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	11	11	11	11	11

Notes - 2011
The District of Columbia has a delay for reporting Birth data this year. Currently 2010 birth data is used to populate information 2011. When the data becomes available this measure will be updated.

Notes - 2010
Preterm births account for the majority of low and very low birth weight births. Reduction in preterm births holds the greatest promise for overall reduction in infant mortality, illness, disability, and death. Preterm births are associated with a number of modifiable risk factors, including the use of alcohol, tobacco, or other drugs during pregnancy and low pre-pregnancy weight or low

weight gain during pregnancy. Other important risk factors for preterm birth are vaginal infections and domestic violence.
The percent of preterm births (number of live births with estimated gestational age < 37 weeks) increased by 5.4 percent between 2009 and 2010. While the percent of infants with a gestational age of 37 weeks or has decreased, the District still has not met its Title V Objective to reduce preterm births by 11 percent.

DC SCHS 2010 birth file.

Notes - 2009
Preterm births account for the majority of low and very low birth weight births. Reduction in preterm births holds the greatest promise for overall reduction in infant mortality, illness, disability, and death. Preterm births are associated with a number of modifiable risk factors, including the use of alcohol, tobacco, or other drugs during pregnancy and low pre-pregnancy weight or low weight gain during pregnancy. Other important risk factors for preterm birth are vaginal infections and domestic violence.

The District anticipates the percent of preterm births will decline by 10 percent from 12.2 percent (2008) to 11 or 11.2 percent by 2015.

.

The demominator reflects a total of 8925 live births, due to missing gestational age for 83 infants. (2009)

a. Last Year's Accomplishments
The percent of preterm births (number of live births with estimated gestational age < 37 weeks) increased by 5.4% from 11% in 2009 to 11.6% in 2010.

See national performance measures 08, 15, 17, 18, and state performance measures 1, 2, 3 and 7, which address risk factors for preterm births.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue Advisory Committee on Perinatal, Infant and Interconceptional Health.		X	X	
2. Continue outreach and coordination with DC jails and shelters to identify potential preterm births.	X			
3. Continue case management services to improve linkages to appropriate medical and social services	X			
4. Continue participation in the Child and Infant Mortality Review committees, review findings and make recommendations.	X			
5. Continue developing a 10-year trend analysis to determine patterns and identify programs and services that reduce preterm births.		X	X	
6. Continue to provide information through the 800 information line.	X	X	X	
7. Continue public information campaigns and launched new campaign to promote pre-conceptual health, I Care about Me.	X	X	X	
8. Partner with the WIC program to reduce nutritional risks for pre-term births.	X	X	X	

9.				
10.				

b. Current Activities

CHA staff will:

• Continue outreach and coordination with DC Jail and shelters to identify pregnant women and refer them to services and entitlements.

• Continue Healthy Start outreach in Wards 5, 6, 7 and 8 and case management services to provide and improve linkages to appropriate medical and social services for pregnant women

• Continue to provide information through the 800 information line

• Continue public information campaigns and launch new campaign to promote pre-conceptual health, "I Care about Me".

• Partner wiith the District's WIC program to reduce nutritional risks for pre-term births

c. Plan for the Coming Year

CHA intends to:

• Attempt to re-activate the Child and Infant Mortality Review Committees and fully participate.

• Examine and participate with DOH and CHA (including Title V and other government agencies) plans that impact directly and indirectly on pregnancy and birth outcomes. Develop cross-agencies priorities and actions. Support and convene advisory groups and involve them in the planning process.

• Continue to raise awareness and educate the public of the dangers of preterm birth, infant mortality risks and preventive measures and community resources

• Continue case management services to improve linkages to appropriate medical and social services for women

• Continue outreach and coordination with DC jails and shelters to identify pregnant women and refer to services and entitlements in efforts to reduce infant mortality

• Evaluate the District's Healthy Start program activities and database functions, reporting capabilities and program outcomes.

State Performance Measure 5: *Percentage of high school students who were in a physical fight on school property one or more times in the past 12 months.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					19
Annual Indicator		20.0	20.0	20.0	20.0
Numerator		330	330	330	330
Denominator		1651	1651	1651	1651
Data Source		CDC-YRBS 2007	CDC-YRBS 2007	CDC-YRBS 2007	CDC-YRBS 2007
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	18	18	18	18	18

Notes - 2011
Source: CDC-YRBS Data System
Data Set: Youth Online
Retrieved on: 05/31/2011 http://apps.nccd.cdc.gov/youthonline/App/Default.aspx

Note: 2009 data is available but it is unweighted, and an inadequate sample size was reported for 2009. The YRBS is conducted every odd year, and 2011 data is not yet available, therefore the most recent data, 2007, was used for 2010 and 2011. When the 2011 becomes available, this measure will be updated.

Notes - 2010
Source: CDC-YRBS Data System
Data Set: Youth Online
Retrieved on: 05/31/2011 http://apps.nccd.cdc.gov/youthonline/App/Default.aspx

Note: 2009 data is available but it is unweighted, and an inadequate sample size was reported for 2009. The YRBS is conducted every odd year, and 2011 data is not yet available, therefore the most recent data, 2007, was used for 2010 and 2011. When the 2011 YRBS data becomes available, this measure will be updated.

Notes - 2009
Source: CDC-YRBS Data System
Data Set: Youth Online
Retrieved on: 05/31/2011 http://apps.nccd.cdc.gov/youthonline/App/Default.aspx

Note: 2009 data is available but it is unweighted, and an inadequate sample size was reported for 2009. The YRBS is conducted every odd year, and 2011 data is not yet available, therefore the most recent data, 2007, was used for 2010 and 2011.

a. Last Year's Accomplishments
As described in the data notes above, the DC Youth Behavior Risk Surveillance Survey data is not current. Efforts to reduce physical fighting were as follows:
1. Addressed risk factors associated with early development of antisocial behavior and adverse maternal health-related behaviors during pregnancy through home visiting efforts in high risk communities. Continued Healthy Start home visits and infant assessments up to age 2.
2. Implemented health education strategies focused on individual youth and their families, as well as neighborhoods and communities.
3. Partnered with Metropolitan Police Department to support key guns and law enforcement strategies.
4. Worked with the Child and Family Services Agency (CFSA) to identify, report and investigate child abuse and neglect.
5. Coordinated health education sessions on child abuse, rape prevention, healthy/unhealthy relationships for youth and parents.
6. Provided bystander education sessions and trained childcare providers on signs of an abused child.
7. Participated in youth-oriented community events to distribute health information on interpersonal violence.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Participating and Reviewing actions for the Mayor's Anibullying Action Plan,		X	X	
2. Continuing collaboration with DC agencies, providers and		X	X	

advocates to address the issues related to children and youth.				
3. Supporting youth development programs to help adolescents avoid risky behaviors.		X	X	
4. Supporting public awareness efforts to educate the community about violence prevention.		X	X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
CHA is:
1. Participating in and reviewing actions for the Mayor's Anti-bullying Action Plan.
2. Continuing collaboration with DC agencies, providers and advocates to address the issues related to violence and children and youth.
3. Supporting youth development programs to help adolescents avoid risky behaviors and make successful transitions to adulthood.
4. Supporting public awareness efforts to educate the community about violence prevention, especially the launch of "I Care About Me" public awareness campaign.

c. Plan for the Coming Year
CHA intends to:
1. Support and implement activities in the Anti-Bullying Action Plan.
2. Support prevention efforts aimed at reducing school violence by increasing security and procedures designed to improve school campus safety. 3. Work with DCPS and charters schools to educate key personnel on violence prevention and conflict resolution.
4. Educate adults who parent or work with teens about the risk factors for violent behavior, and expand mental health services for troubled teens.
5. Continue home visiting services to high risk families in each District ward.
6. Discuss partnership with schools on youth violence efforts.

State Performance Measure 6: *Prevalence of Elevated Blood Lead among children less than 6 years of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					1
Annual Indicator			0.6	1.0	0.3
Numerator			81	201	43
Denominator			13653	19967	15673
Data Source			DC 2009 Lead Trax Database	DC 2010 Lead TRAX	DC 2011 Lead TRAX
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**

Annual Performance Objective	1	1	1	1	1

Notes - 2011
During the last 11 years, the number of children with elevated blood lead levels decreased by 92 percent. To highlight the continued downward trend, between 2009 and 2010 the prevalence of children aged six and under declined by fifty percent from 0.6 in 2009 to 0.3 percent in 2010

Data obtained from the District of Columbia Department of the Environmental (DDOE) Lead TRAX data base who have at least one positive test result (ELB >= 10 ug/dl) in calendar year 2011.

The denominator reflcts the number of children screened at least once.

Notes - 2010
Data obtained from the District of Columbia Department of the Environmental (DDOE) Lead TRAX data base. There were 90 new incidences of EBL in CY 2010; there were 111 new plus ongoing EBL cases during CY 2010.

Numerator :201 (90 new incidences and 111 ongoing cases CY2010)

Denominator: United States Census. Annual Estimates of the Resident Population by Sex and Age for the District of Columbia: April 1, 2000 to July 1, 2009.

a. Last Year's Accomplishments
In 2010, DDOE staff conducted home visits for 90 cases of children with a blood lead level greater than or equal to 10 µg/dL. During the same period, DDOE's sub-grantee conducted home visits on DDOE's behalf in 59 cases of children identified with a blood lead level equal to or greater than 5 µg/dL but below 10 µg/dL.

During the last 11 years, the number of children with elevated blood lead levels decreased by 92%. DDOE's Lead and Healthy Housing Division is the District's focal point for lead poisoning prevention activities. The Division consists of two branches. One has responsibility for the District's Childhood Lead Poisoning Prevention Program, including (a) being the repository for all blood lead data for District residents under the age of 6 years, (b) conducting epidemiologic analyses of the blood lead data and issuing evidence-based policy recommendations, (c) providing case management services to all children under the age of 6 years who have a blood lead level (BLL) = 10 micrograms of lead per deciliter of blood (µg/dL), and (d) conducting primary prevention activities for pregnant women and for children under the age of 6 years who have a BLL = 5 µg/dL and <10 µg/dL, through the services of the Division's sub-grantee, Lead-Safe DC (the National Nursing Centers Consortium), and in collaboration with CHA.

The other branch enforces the District's lead laws, performs environmental investigation activities in cases of children with a BLL = 10 µg/dL, and responds to complaints about unsafe work practices and the generation of other potential lead hazards. CFSA continues to refer properties to DDOE when the occupants apply to become foster parents of children under the age of 6 years. The prospective foster care home must be proven to be lead safe. DDOE staff speaks about lead at orientation sessions for prospective foster parents, and DDOE staff undertakes housing inspections to ensure the homes are lead safe.

DDOE became the first jurisdiction in the nation to install and operate a new CDC database, called Healthy Homes and Lead Poisoning Surveillance System (HHLPSS). Also in February 2011, DDOE authored and disseminated widely a letter to pediatricians, OBGYNs, family practices, health clinics and MCOs serving District residents, describing the results of a December 2010 CDC epidemiology study about the health implications of lead in the District's tap water. The letter includes recommendations for providers whose patient include pregnant women

or young children. The letter was signed by the Directors of DDOE, DOH and DHCF, and by the General Manager of WASA. In July 2011, DDOE published proposed regulations to fully implement the District's lead law.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. DDOE receives referrals from medical providers and others of homes thought to be contributing to children's health problems and works with the property owner to address the environmental health hazards.	X			
2. CFSA (Child and Family Services Agency) And DDOE staff work together to speak about lead at orientation sessions for prospective foster parents.		X	X	
3. DDOE continues to work closely with several other District agencies to verify that agencies are all complying with the District lead law.		X	X	
4. DDOE continues to convene and chair quarterly interagency meetings on lead.		X	X	
5. DDOE aggressive campaign to increase second blood screens for lead exposure.		X	X	
6. Stakeholder meetings to discuss the new lead laws.		X	X	
7.				
8.				
9.				
10.				

b. Current Activities

During calendar year 2011, DDOE staff conducted initial home visits for 42 children with a newly identified blood lead level =10 µg/dL. During the same time period, an additional 79 children with a blood lead level ranging from 5µg/dL to 9.9 µg/dL received an initial home visit through DDOE's sub-grantee, Lead Safe DC.

DDOE's Lead and Healthy Housing Division remains the District's focal point for lead poisoning prevention activities. DDOE receives referrals from medical providers and others of homes thought to be contributing to children's health problems, in particular asthma. DDOE inspects those homes and works with the property owner to address the environmental health hazards it identifies, in collaboration with a variety of partners. CFSA and DDOE staff work together to speak about lead at orientation sessions for prospective foster parents.

In 2012, DDOE is working closely with the DC Housing Authority (DCHA), providing technical assistance as DCHA embarks on a comprehensive lead poisoning prevention program for its public and assisted housing stock. In January 2012, DDOE and DOH executed an MOU, for a series of focus group sessions involving parents and caregivers of District children who have not received timely blood lead tests.

c. Plan for the Coming Year

1) DDOE will continue to execute all programs and activities described in (a) and (b) above.
2) DDOE will join with DCRA to streamline the District's permitting process, by adding staff that can address the need for lead abatement permits for those DCRA permit applicants whose work will be disturbing paint in pre-1978 residential housing or child-occupied facilities.

3) DDOE will expand its lead enforcement program to focus increasingly on proactive enforcement, resulting in increased primary prevention with respect to lead poisoning.
4) DDOE will seek authorization from US EPA to administer and enforce the Renovation, Repair and Painting Rule.

State Performance Measure 9: *Percent of women who intiated care in the first trimester. (Kessner index)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					80
Annual Indicator		78.8	78.8	70.0	70.0
Numerator		7197	7197	4420	4420
Denominator		9134	9134	6318	6318
Data Source		SCHS 2008 Birth File	2008 SCHS Birth File	SCHS Birth file 2010	SCHS 2010 Birth file
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	80	80	80	80	80

Notes - 2011
The District experiences a 2-year delay in vital statistics reporting. For this measure, 2010 data is used. When the 2011 data becomes available, this measure will be updated.

The Kessener index is not used here. The number of visits is not captured on the birth certificate. However, the birth certificate captures information on trimester of entry into care and no prenatal care. That data element was used to calculate the number of women who initiated care by trimester and is used to populate this measure. Trimester of entry into care was collected on birth certificates for only 6,618 live births although there were 9,156 live births to District residents in 2010.

Notes - 2010
The Kessner index is not used here. Instead, based on the available data, the District vital statistics file, the number of visits is not captured on the birth certificate. However, the number of women who initiated care by trimester is calculated- and is used here to populate this measure. In addition, only 6,618 live births captured this information on the birth certificate, (although there were 9156 live births to District residents (this number is used as the denominator and the numerator is the number of women who began prenatal care in the first trimester.
Source: District of Columbia SCHS 2010 Birth file.

Notes - 2009
Data for 2008 is reported here until 2009 information can be obtained. This is due to a change in migrating from the onld NCHS birth certificate to the new 2003 format. This information is expected to be revised when the final 2009 birth file is obtained.

a. Last Year's Accomplishments
See national performance measure 18.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue public awareness campaigns (I am a Healthy DC MOM and I am a Healthy DC BABY).		X	X	
2. Continue annual Baby shower events in May.		X	X	
3. Continue to increase oversight and effectiveness of the Healthy Start program's nurse case management to encourage PNC in subsequent births.		X	X	
4. Continue to recruit, train and deploy new Family Support Workers under the Healthy Start program to provide complementary support services that address psycho-social risk factors affecting pregnant and parenting women and their children.	X	X	X	
5. Continue to implement the public information campaign educating women, including those who are not yet pregnant, and their families about the critical role of comprehensive preconception and prenatal care in ensuring a healthy pregnancy.	X	X	X	
6. Continue early identification of pregnancy and ensure timely enrollment in PNC for all women of child-bearing age under Medicaid and the DC HealthCare Alliance.	X	X	X	
7. Collaborates with DHCF to increase well-child pediatric visits throughout the first year of life for all newborns on Medicaid, in particular.		X	X	
8. Continue efforts with HAHSTA to promote routine prenatal HIV testing and treatment that prevents perinatal HIV transmission to the infant.		X	X	
9. Developing linkage to mental health and substance abuse education and treatment services.				X
10.				

b. Current Activities

CHA staff will:

1 Continue public awareness campaigns (DC MOM and BABY).

2. Continue annual Baby shower event in May.

3 Continue to increase oversight and effectiveness of the Healthy Start program's nurse case management to encourage PNC in subsequent births.

4 Continue to recruit, train and deploy new family support workers under the Healthy Start program to provide complementary support services that address psycho-social risk factors affecting pregnant and parenting women and their children.

5. Continue to implement the public information campaign educating women, including those who are not yet pregnant, and their families about the critical role of comprehensive preconception and prenatal care in ensuring a healthy pregnancy, birth, and infancy.

6. Continue early identification of pregnancy and ensure timely enrollment in PNC under Medicaid and the DC HealthCare Alliance.

7. Continue efforts with HAHSTA to promote routine prenatal HIV testing and treatment that prevents perinatal HIV transmission to the infant.

9. Develop linkages to mental health and substance abuse education and treatment services.

c. Plan for the Coming Year

CHA plans to:
1 Continue public awareness campaigns.
2. Continue annual Baby shower event in May.
3 Continue to increase oversight and effectiveness of the Healthy Start program's nurse case management to encourage PNC in subsequent births.
4 Continue to recruit, train and deploy new family support workers under the Healthy Start program to provide complementary support services that address psycho-social risk factors affecting pregnant and parenting women and their children.
5. Continue to implement the public information campaign educating women, including those who are not yet pregnant, and their families about the critical role of comprehensive preconception and prenatal care in ensuring a healthy pregnancy, birth, and infancy.
6. Continue early identification of pregnancy and ensure timely enrollment in PNC for all women of child-bearing age under Medicaid and the DC HealthCare Alliance.
8. Continue efforts with HAHSTA to promote routine prenatal HIV testing and treatment that prevents perinatal HIV transmission to the infant.
9.Strengthen linkages to mental health and substance abuse education and treatment service

E. Health Status Indicators

/2013/ Continuing to make progress toward the elimination of disparities in perinatal health and particularly in the reduction of the infant mortality rate (IMR) is a highly visible priority in the District. The Title V program has placed the reduction of infant mortality high on the list of priorities for years, recognizing that in addition to the infant deaths per se, this indicator reflects a great deal about the overall health of the population. Therefore, government officials, providers and advocates all have an interest in the status indicators related to prenatal care, and low and very low birth weight as well as the IMR. These performance and outcome measures are described in other sections of this report.

The release of the 2010 births and infant deaths data in April 2012 revealed that the IMR had declined from 10.6 in 2001 to 8.0/1000 in 2010 thereby reaching the Title V objective for 2013 (and exceeding the objective for 2010) and the DC Healthy People target for 2010. This welcomed decline occurred over a decade in which both the District's population and the number of births increased. As described in another section of this report, from 2000 to 2010 the African American population declined by 38,000 and the Caucasian population grew by about 50,000, meaning that the District is no longer a majority African American city.

It is important to recognize that according to the DOH Center for Policy, Planning, and Evaluation's report, the overall reduction in infant mortality rates may be explained by large declines in infant deaths to Non-Hispanic Black women among whom the IMR fell from 14.5 in 2001 to 10.5/1000 in 2010. Although the Non-Hispanic white IMR increased from 2.8 in 2001 to 4.9/1000 in 2010, the number of infant deaths among the white population involves very small numbers and is therefore too unstable to indicate annual trends. The IMR rate of 3.7/1000 among Latinas compared favorably to their US rate of 5.5/1000. Outcome measure #02 (ratio of Black IMR to white IMR), an indicator of disparity, was 2.0 in 2010, a decline from previous years but continuing to reflect the great disparities in health among the DC population. The decline in the 2010 IMR applied to both the neonatal and the postneonatal rates.

As shown on Form 20 Health Status Indicator #01A, the proportion of low birth weight (LBW) births ranged from 11.1% in 2007 to 10.2% in 2010 and for singletons 9.3 to 8.0% during that period. Considering social characteristics, 13.3% of births to DC Non-Hispanic Black women were of LBW, compared to 6.7% to Latinas, and 6.4% to Non-Hispanic whites.

The 5 DC-based FQHCs reported (UDS) in 2010 that 7.6% of births to their 4903 prenatal patients were of LBW (http://bphc.hrsa.gov/uds/view.aspx?year=2010&state=DC). If one can assume the total number of patients includes no or few duplicates, the FQHCs provided prenatal care for roughly half of DC births. The FQHCs' LBW ranged from 2.04% (Community of Hope) to 8.97% for Unity Health Care, which operates the greatest number of clinic sites. The DOH Healthy Start project reports on the performance objective of African American women enrolled in its case management services who deliver LBW infants. (Healthy Start does not provide medical services.) In 2011, 15.7% of wards 7 and 8 clients and 16.2% of wards 5 and 6 clients delivered LBW infants. These percentages are mentioned for purposes of description only. An unknown number of cases overlap; many Healthy Start clients receive prenatal care at one of the FQHCs and presumably the majority of FQHC patients receive Medicaid-SCHIP.

Over this same period, as shown for Health Status Indicator #02A, the very low birth weight births (VLBW) declined from 2.9 in 2007 to 2.4% of all births. For singletons the change was from 2.3 to 1.7%. In 2011, 1.9% of the Healthy Start wards 7 and 8 enrollees and 2.7% of the wards 5 and 6 enrollees delivered VLBW infants. Over the past 4 years the proportion of VLBW infants delivered at Level III and IV facilities increased from 76% to 90.5% (performance measure #17), possibly suggesting better planning for delivery of high risk births.

According to National Center for Health Statistics data the proportion of preterm births in the District declined significantly over a 5-year period--from 16.0 in 2006 to 13.5% in 2010. (Note that this number is not the same as found in state performance measure #4.) In general, these recent, gradual declines in infant deaths, low birth weight and prematurity in the District parallel similar trends in the general U.S. population.

Over the past decade the District's approach to improving health status appears has seen the increase the availability of medical care. For many years, Unity Health Care was the single FQHC in the District; in the past several years four smaller health centers have qualified, opening up new sources of revenue and enabling their expansions and most likely improvements in quality. The number of school-based health centers increased to 5. In addition to federal grants and expanded Medicaid-SCHIP coverage, the District government funded this growth with tobacco settlement funds. Moving into the era of health finance reform, the District's low income population may be expected to have improved access to medical services.

Improvements in infant mortality are not explained by the percentage of women who entered prenatal care in the first trimester, which changed from 73% in 2007 to 70% in 2010 (performance measure #18). In 2010, more than 83% percent of white women who gave birth entered care in the first trimester, compared to 63% of Latinas and 61% of African Americans. About 6.8% of women began care late or had no prenatal care at all; two-thirds of them were Black women. (As noted in performance measures notes, a rather high number of birth certificates did not capture trimester of entry.) Entry into prenatal care in the first trimester reported by FQHCs ranged from 69.6% for Unity to 83.3% at Columbia Road Health Center.

Since 1991, the DOH has operated the Healthy Start project, which aims to identify pregnant women with high social (and medical) risks, enroll and maintain them in nurse case management services, and ensure that they receive medical care. The project, as well as the Mary's Center Healthy Start project, conducts home visiting, a strategy for which there is evidence that it improves infant outcomes. The MCHB home visiting grant will increase the capacity of DC organizations to provide home visit services. As described in other sections of this report, CHA now operates the Safe Cribs program, which distributes pack-n-plays and standard cribs to needy families that would otherwise bed-share with

their infants. A number of these families reside in shelters. Recipients of the beds and Healthy Start clients complete a 2-hour workshop on Sudden Infant Death Syndrome (SIDS)/Safe Sleep. In conjunction with a SAMHSA Fetal Alcohol Spectrum Disorder (FASD) grant, both community workers and families are receiving information on the dangers of drinking during pregnancy. Similar efforts are directly toward tobacco use.

Several multi-media campaigns are in place to increase public awareness of healthful practices, which are expected to improve pregnancy and birth outcomes as well as general health factors: "I am a Healthy DC Mom; "I am a Health DC Dad"; "I am a Healthy DC Baby", and, the most recently launched, "I Care About Me", which are directed to preconception health.
//2013//

An attachment is included in this section. IVE - Health Status Indicators

F. Other Program Activities

Lead Program
With newly enacted comprehensive lead legislation, the DDOE Lead Program performed proactive lead inspections in order to identify lead problems and have them remediated, prior to a child being exposed to lead. In the event of elevated blood lead levels (5 -10 ug/dL) DDOE tests the child's home for the source of the lead. DDOE collaborates with CHA and DHCF to monitor these children at risk before their levels reach 10ug/dL.

A summary of the 2010 activities:

Family Voices of DC (FVDC) and CSHCN
CHA collaborates with Family Voices, an organization that is affiliated with the national Family Voices network whose mission is to "achieve family-centered care for all children and youth with special health care needs and or disabilities." Through its national network presenting 50,000 families of children with special health care needs, and Family to Family agencies in fifty states and the District of Columbia, it provides families with tools to make informed decisions about services for their children, advocate for improved public and private policies, build partnerships among professionals and families and serve as a trusted resource for families on therapeutic and health care decisions. FVDC is integral in the CSHCN Advisory Board and a partner in the transition program with National Alliance to Advance Adolescent Health.

The National Alliance to Advance Adolescent Health collaborates with the Department of Medicine George Washington University Medical Center, the Department of Community and Family Medicine of Howard University Medical Center, Adams Morgan Children's Health Center, Mary's Center, HSCSN, Family Voices-DC and national partners at Healthy and Ready to Work and the Center for Medical Homes Improvement collaborate with CHA to provide leadership in implementing the core transition outcome to achieve continuity within the medical home model of care between pediatric and adult health care systems.

The Oral Health Program has partnered with Howard University School of Dentistry, Children National Hospital Center dental Pediatric Residency program and St Elizabeth's Hospital Dental General Practice Residency Program to provide clinical rotation sites to the school based oral care. This provides an opportunity for residents and dental hygiene students to develop their clinical skills as well as enhance their cultural competency. The primary challenges in providing oral health services is securing permission from parents.

The Program continues its support to allow non-dental health providers to administer fluoride varnish to children during ESPDT visits. The Program objectives for 2010 include: expand fluoride varnish and dental sealant programs in DC schools; expand fluoride varnish and dental sealant programs in DC schools; establish an oral health network to develop local solutions to access to

care problems; augment the partnership with Howard University Dental School to recruit and train oral health practitioners to provide services in schools including Head Start programs; improve the ability to collect epidemiological surveys, and data collection, tracking and evaluation of oral health services and programs.

CYSHCN Statewide Symposium - The CHA awarded a sub grant to Georgetown University to plan and convene a 1-day meeting of key stakeholders in creating/improving a system of care for CYSHCN in DC. These focus groups and key informant interviews will be used to begin the framework for the CYSHCN State Plan and will also be used to help guide the discussions during the Symposium. Georgetown University will also receive a sub grant to develop a District-wide Parent Advocacy Network with the aim of training and educating parents and families of CYSHCN to become Parent Leaders to encourage them to be advocates for children in their communities, become engaged as community activists, and assist other parents to do the same things.

Medical Homes Pilot -- CHA awarded a sub-grant to Children's National Medical Center (CNMC) to develop and implement a medical homes initiative in two of its sites. This initiative will utilize parent navigators (who are also parents of CYSHCN) to help other families navigate the health care system.

Improving the Life of Special Needs Children: Transitioning from Pediatric to Adulthood -- CHA awarded a sub grant to the National Alliance to Advance Adolescent Health to conduct an analysis of the challenges faced by Youth with Special Health Care Needs as they transition to adulthood. T he Alliance convened focus groups consisting of both youth and families.

Development of Three New School Health Clinics
The DC Assembly on School Health Care (DC Assembly) is a coalition of organizations and individuals committed to providing quality and accessible health care for children and adolescents in the District of Columbia. The DC Assembly was founded to provide coordinated efforts to increase the availability of health care for at-risk and medically underserved populations through partnerships involving schools and health care providers. The goals of the DC Assembly included: 1) Establish sustainable school-based health care programs at 10 sites in the District by 2010; 2) Establish the DC Assembly as the policy leader for school-based health care in DC; 3) Establish strategic relationships with other groups, agencies, and associations to develop a clear delineation of roles and responsibilities for advocacy and support of SHCs in DC; 4) Work with City leaders to pass legislation and regulations to establish a funded and integrated SHC program; 5) Secure approval of Medicaid funding for child health services delivered in SHCs; and 6) Establish organizational capacity to support an ongoing program of policy development, advocacy, school recruitment, provider recruitment, and technical assistance for school-based health care programs.

Summer Camp - Title V sponsored 4 camps during summer 2010 to allow children with special health care needs the ability to have a normal camp experience. The camps had a total of 163 children from DC; 60% of children were from Wards 7 and 8. The included: Camp Happy Lungs through UMC/Breathe DC (asthma, respiratory disorders); Camp Round Meadow through HSCSN Inc.(respite camp for CSHCN); Fitness for Health Kamp for Kids, (Sensory/GrossMotor Camp) and Associates for Renewal in Education ARE Therapeutic Camp (behavioral/emotional needs camp).

/2012/The Pediatric Citywide Forum committees included one overarching systemic issues committee/creating a build environment. They proposed goals such as:
1. To develop and maintain a central website with reliable and timely pediatric health information presented in a way agencies and citizens can use them.
2. To increase programs that emphasize prevention and wellness by engaging families in health behaviors and increasing health literacy.
3. To propose adjusting reimbursement rates to attract health care services that are lacking in Washington DC

4. To create school health programs to incorporate modules on the city's most pressing health issues.
5. To create intensive primary care programs for children.
While the plan is not completed outcomes will be reported next year.//2012//

An attachment is included in this section. IVF - Other Program Activities

G. Technical Assistance

CHA did not request technical assistance from HRSA for the 2010 grant year.
The technical assistance needs for the 2011 grant year include:
1 Developing strategies to evaluate child deaths in DC due to intential injuries, suicide, suicidal ideation, and homicide.
2 Evaluate service and program capacity for children with special health care needs and their parents/caregivers.
3 Assistance with the development of a Youth Action Plan.
4 Develop strategies to implement the Katy Beckett waiver for emergency care funding for DC residents who
would not otherwise qualify for Medicaid.
5 Assistance to strengthen the cultural awareness and competence of CHA staff, and subgrantees and their programs.
6 Identify and develop data integration strategies.
7 Assessment of prevalence of subpopulations of CYSHCN and their experience with care in the district.

/2012/CHA did not request technical assistance from HRSA for the 2011 grant year since a few efforts were accomplished through other DOH efforts. CHA does welcome HRSA assistance to evaluate social media campaigns, and identify vendors for the following list of TA requests.

The technical assistance needs for the 2012 grant year include:
1 Identifying a Lifecourse Model; and suggestions on how to implement the model throughout all CHA programs.
2. Evaluation of the needs of the special needs population and their parents/caregivers. Stakeholders have expressed a lack of knowledge of programs in DC. Assistance is needed to evaluate the actual perceived needs.
3. Assessment of the prevalence of special needs in the District. Prevalence of special needs children is not directly known in DC, which usually accepts the national prevalence and applies it to our population.
4. Developing data integration strategies. TA is requested to help enhance collaborative planning to monitor maternal and child health in the district. What systems changes are needed?
5. Enhancing cultural competence among staff and subgrantees. CHA does not have the expertise to ensure the cultural competence of its subgrantees. What methods have been used in other states to ensure this?
6. Identifying strategies to evaluate child deaths in DC, due to homicide and suicide. Infant mortality and gun violence are the two major causes of death in DC. //2012//

/2013/CHA did not request technical assistance from HRSA in 2011-2012 grant year. With staff changes the need to fill these requests were halted until stable leadership were introduced. CHA does welcome HRSA advice on vendors that would be able to assist us with any of the following TA requests.

The technical assistance needs for the 2013 grant year include:
1. Develop a method for ensuring cultural competence among subgrantees.
2. Developing a plan to implement the life course model throughout all CHA programs
3. Evaluation of services and programs and needs of the special needs population and

their parent/caregivers.
4. Evaluation of the impact of current DOH programs for all those people living at or below the poverty level.
5. Developing data integration strategies.
6. Evaluation of the DC LInkage and Tracking System (DCLTS).
//2013//

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2011		FY 2012		FY 2013	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	7066666	6218338	7064107		7034280	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	5300000	5770999	5298122		5300000	
4. Local MCH Funds *(Line4, Form 2)*	0	0	0		0	
5. Other Funds *(Line5, Form 2)*	0	0	0		0	
6. Program Income *(Line6, Form 2)*	0	0	0		0	
7. Subtotal	12366666	11989337	12362229		12334280	
8. Other Federal Funds *(Line10, Form 2)*	34532848	32488692	28746141		25074640	
9. Total *(Line11, Form 2)*	46899514	44478029	41108370		37408920	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2011		FY 2012		FY 2013	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	1460000	1059211	1460000		1000000	
b. Infants < 1 year old	500000	481991	500000		500000	
c. Children 1 to 22 years old	5406666	4922662	5402229		6203428	
d. Children with	2300000	2716194	2300000		2110300	

Special Healthcare Needs						
e. Others	2350000	2390423	1993589		1817124	
f. Administration	350000	418856	706411		703428	
g. SUBTOTAL	12366666	11989337	12362229		12334280	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	100000		100000		65357	
c. CISS	105000		132000		150000	
d. Abstinence Education	0		0		0	
e. Healthy Start	3700000		3700000		3700000	
f. EMSC	0		0		0	
g. WIC	20431486		13522363		14872435	
h. AIDS	0		96200		0	
i. CDC	8940362		10249403		5286848	
j. Education	0		0		0	
k. Home Visiting	0		0		1000000	
k. Other						
Project Launch	850000		850000		0	
State Implementation	300000		96175		0	
TBI	106000		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2011		**FY 2012**		**FY 2013**	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	2300000	2716194	2300000		2700000	
II. Enabling Services	3688881	2387846	3062229		2400000	
III. Population-Based Services	4861330	5248452	5300000		5594280	
IV. Infrastructure Building Services	1516455	1636845	1700000		1640000	
V. Federal-State Title V Block Grant Partnership Total	12366666	11989337	12362229		12334280	

A. Expenditures

/2011/ Completion of Budget Forms: Please refer to forms 2, 3, 4, and 5 for a summary of how MCH funds were budgeted and expended.

The FY2010 Award $ 7,091,016

The percentage of FY010 earmarking requirements included:

30% children with special health care needs: $ 2,120,000

YTD Personnel Services $ 716,976

YTD Non personnel services $ 456,875
Total expenditures $ 1,173,851

Earmarking requirements 30%

30% FY2010 Preventive and Primary Care Earmarking $ 2,120,000

YTD Personnel Services $ 316,779
YTD Non personnel services $ 267,144
Total expenditures $ 583,923

Earmarking requirements 30%

10% Administrative threshold $709,101

YTD FY10 expenditures on administration $ 350,000
% of FY10 Administrative threshold 4.9528 % //2011//

/2010/
Completion of Budget Forms: Please refer to forms 2, 3, 4, and 5 for a summary of how MCH funds were budgeted and expended.
The FY2010 total partnership award was $ 7,064,107. The District of Columbia expended $5,298,122 in local funds. This amount is slightly higher than the statutory maintenance of effort level from FY1989 of $5,288,000.
The District met its earmarking requirements by expending at least 30% of the partnership award on Children with Special Health Care Needs, 30% of the award on Preventive and Primary Care Services and no more than 10% on Administrative cost.
The method for identifying State expenditures on the various earmarking categories is achieved by identifying the appropriate cost centers for each specific area of MCH activities. Data on expenditures is obtained from reports issued by the Office of the Chief Financial Officer. The expenditures represent payments made on cash-basis accounting method. The partnership award funds are identified and tracked using a unique funding identification number. The funds are segregated into specific objects of expense within each cost center.
Methodology: The State makes every effort to use the data collected by the Department of Health and other entities to direct MCH funds to address unmet needs. On a quarterly basis the Maternal and Family Health Administration proportions program expenditures to reflect percentage of effort in direct health care services, infrastructure-building, population-based services and enabling services. Program expenditures are also proportioned based on the "30-30-10" earmarking requirement of Title V.
//2010//

/2011/
EXPENDITURES
FY2011 award $7,067,556
In fiscal year 2011 the DC Department of Health Community Health Administration (CHA) expended $6,218,338 in MCH Title V funds.
The Percentage of FY11 earmarking requirements, based on actual expenditures is:
30% for Children with Special Health Care Needs - $1,865,501
Actual expenditures on Children with Special Health Care Needs in fiscal year 2011 was $2,716,194. This constitutes 44% of federal MCH Title V funds received and 23% of total expenditures for Title V services.
30% for Preventive and Primary Care - $1,865,501
Actual expenditures on Preventive and Primary Care in fiscal year 2011 was $2,387,846. This represents 38% of federal MCH Title V funds received by the state and 23% of total expenditures on Title V services.
10% Administrative threshold - $621,834

Actual Administrative expenditures in fiscal year 2011 were $418,856. This total represents 6.7% of federal MCH Title V funds received by the state and 3.5% of total expenditures on Title V services.
The District met its earmarking requirements by expending at least 30% of the partnership award on Children with Special Health Care Needs, 30% of the award on Preventive and Primary Care Services and no more than 10% on Administrative cost.
The method for identifying State expenditures on the various earmarking categories is achieved by identifying the appropriate cost centers for each specific area of MCH activities. Data on expenditures is obtained from reports issued by the Office of the Chief Financial Officer. The expenditures represent payments made on cash-basis accounting method. The partnership award funds are identified and tracked using a unique funding identification number. The funds are segregated into specific objects of expense within each cost center.
Methodology: The State makes every effort to use the data collected by the Department of Health and other entities to direct MCH funds to address unmet needs. On a quarterly basis the Maternal and Family Health Administration proportions program expenditures to reflect percentage of effort in direct health care services, infrastructure-building, population-based services and enabling services. Program expenditures are also proportioned based on the "30-30-10" earmarking requirement of Title V. //2011//

/2012/
Completion of Budget Forms: Please refer to forms 2, 3, 4, and 5 for a summary of how MCH funds were budgeted and expended.
The FY2010 total partnership award was $ 7,064,107. The District of Columbia expended $5,298,122 in local funds. This amount is slightly higher than the statutory maintenance of effort level from FY1989 of $5,288,000.
The District met its earmarking requirements by expending at least 30% of the partnership award on Children with Special Health Care Needs, 30% of the award on Preventive and Primary Care Services and no more than 10% on Administrative cost.
The method for identifying State expenditures on the various earmarking categories is achieved by identifying the appropriate cost centers for each specific area of MCH activities. Data on expenditures is obtained from reports issued by the Office of the Chief Financial Officer. The expenditures represent payments made on cash-basis accounting method. The partnership award funds are identified and tracked using a unique funding identification number. The funds are segregated into specific objects of expense within each cost center.
Methodology: The State makes every effort to use the data collected by the Department of Health and other entities to direct MCH funds to address unmet needs. On a quarterly basis the Maternal and Family Health Administration proportions program expenditures to reflect percentage of effort in direct health care services, infrastructure-building, population-based services and enabling services. Program expenditures are also proportioned based on the "30-30-10" earmarking requirement of Title V.
//2012//

/2013/
FY2011 award $7,067,556
In fiscal year 2011 the DC Department of Health Community Health Administration (CHA) expended $6,218,338 in MCH Title V funds.

The Percentage of FY11 earmarking requirements, based on actual expenditures is:
30% for Children with Special Health Care Needs - $1,865,501
Actual expenditures on Children with Special Health Care Needs in fiscal year 2011 was $2,716,194. This constitutes 44% of federal MCH Title V funds received and 23% of total expenditures for Title V services.
30% for Preventive and Primary Care - $1,865,501
Actual expenditures on Preventive and Primary Care in fiscal year 2011 was $2,387,846. This represents 38% of federal MCH Title V funds received by the state and 23% of total expenditures on Title V services.

10% Administrative threshold - $621,834
Actual Administrative expenditures in fiscal year 2011 were $418,856. This total represents 6.7% of federal MCH Title V funds received by the state and 3.5% of total expenditures on Title V services.
The District met its earmarking requirements by expending at least 30% of the partnership award on Children with Special Health Care Needs, 30% of the award on Preventive and Primary Care Services and no more than 10% on Administrative cost.

The method for identifying State expenditures on the various earmarking categories is achieved by identifying the appropriate cost centers for each specific area of MCH activities. Data on expenditures is obtained from reports issued by the Office of the Chief Financial Officer. The expenditures represent payments made on cash-basis accounting method. The partnership award funds are identified and tracked using a unique funding identification number. The funds are segregated into specific objects of expense within each cost center.
Methodology: The State makes every effort to use the data collected by the Department of Health and other entities to direct MCH funds to address unmet needs. On a quarterly basis the Maternal and Family Health Administration proportions program expenditures to reflect percentage of effort in direct health care services, infrastructure-building, population-based services and enabling services. Program expenditures are also proportioned based on the "30-30-10" earmarking requirement of Title V.
//2013//

An attachment is included in this section. VA - Expenditures

B. Budget

/2011/ The DOH allocates Title V funding according to the defined categories described in the Application Guidance: 30% for preventive and primary care services for children; 30% for services for children with Special Health Care Needs; 30% for planning, administration, evaluation and education; and 10% for grant administration. The following presents the budget narrative to support personnel; programmatic and other related expenses for 2010.

Personnel Budget Narrative $4,190,378
The proposed personnel budget includes program, administrative and support staff positions described below. The total salary cost is $4,190,378 and includes fringe benefits (.1794). The total personnel budget is $ 4,190,378, supporting 61.5 FTEs.

Title V fund allocation for staff is limited to the Administration, Perinatal and Infant Health Bureau, and Child, Adolescent and School Health Bureau.

Chief, Office of Grants Management
Administrative Officer
Epidemiologist
Executive Assistant
Grants Management Specialist
Program Analyst
Program Specialist
Project Coordinator
Public Health Advisor
Public Health Analyst
Receptionist
Statistical Assistant

Non Personnel Budget Narrative - $2,900,638

CHA proposes the following funding allocations to support the objectives of the Title V grant.

1) Allocate up to $400,000 in evidence-based Teen Pregnancy Prevention Programs, to enhance evidence-based programming to reduce teen pregnancy
2) Allocate up to $100,000 for a Childhood Obesity Prevention/Breastfeeding Promotion imitative to create Baby-Friendly Hospitals in DC
Supplement local and other federal funds to reduce childhood obesity.
3) Allocate up to $200,000 to address mood, emotional, developmental or cognitive disorders and prevent intentional injury These funds should be used to enhance capacity for and access to services for children and youth with mood, emotional,
developmental or cognitive disorders and their families.
4) Allocate up to $250,000 for a Pediatrics-to-Adult Transition Program to improve coordination of care for CYSHCN - The program is expected to support the transition of children with special health care needs from pediatric to adult services through a case management program.
5) Allocate up to $250,000 for a Parent Information Network - The scope of work will include expansion of navigation services to families with children with special needs; provision of referrals to parent support, home education, and parent skills training; development of a resource directory of state and regional services for children with special health care needs; leadership training for parents/caregivers; and cultural competency training for providers.
6) Allocate up to $200,000 for Pediatric Asthma Control
Enhance capacity for and access to services for children and youth with asthma and their families.
8) Allocate up to $150,000 for Sickle Cell Disorder
Enhance capacity for and access to services for children and youth with sickle cell disorder and their families.
9) Allocate up to $1,000 to pay for up to 3 members of the CSHCN Advisory Board to attend the AMCHP conference. CHA will determine eligibility based on need and willingness to provide presentations to the advisory board.
10) Allocate up to $30,000 for Title V Staff Training used to support the professional development of program staff.
11) Allocate up to $33,750 for OCTO to provide information technology maintenance services includes help desk support and trouble shooting for technology issues. Costs are estimated at $750 per year time for an estimated 50 personal computers.
12) Allocate up to $200,000 for enabling services to increase access to quality health care for children, youth and children/youth with special health care needs.
13) Allocate up to $100,000 to continue the Family Navigation program, including transition of web site.
14) Allocate up to $200,000 for Prevention of Sexually Transmitted Infections Among Youth
Enhance capacity for and access to preventive and treatment services for sexually transmitted infections among youth
15) Allocate up to $100,000 for Oral Health
Enhance capacity for and access to oral health services for children and youth

Any additional funds will be used to cover emerging priorities and unanticipated expenses.
Maintenance of Effort/State Match
The District of Columbia expended $6,148,876 in state funds in providing services to the Title V population. This amount is $860,876 in excess of the $5,288,000 MOE requirement and $860,876 in excess of the $5,300,000 state match requirement. The MOE and matching funds are used to provide nursing services to all students attending District of Columbia public and public charter schools.//2011//

/2012/
The DOH allocates Title V funding according to the defined categories described in the Application Guidance: 30% for preventive and primary care services for children; 30% for services for children with Special Health Care Needs; 30% for planning, administration,

evaluation and education; and 10% for grant administration. The following presents the budget narrative to support personnel; programmatic and other related expenses for 2012.

Personnel Budget Narrative
The proposed personnel budget includes program, administrative and support staff positions described below. The total salary cost is $3,819,912.79 and includes fringe benefits (.1952). The total personnel budget is $4,565,177.77 supporting 53.80 FTEs.
Title V fund allocation for staff is limited to the Administration, Perinatal and Infant Health Bureau, and Child, Adolescent and School Health Bureau.
Chief, Office of Grants Management
Administrative Officer
Epidemiologist
Executive Assistant
Grants Management Specialist
Program Analyst
Program Specialist
Project Coordinator
Public Health Advisor
Public Health Analyst
Receptionist
Statistical Assistant

Non Personnel Budget Narrative
CHA proposes the following funding allocations to support the objectives of the Title V grant.

1) Up to $400,000 in an RFA CHA070111 for Direct Services. Such services may include, but are not limited to:
Pediatric Asthma Control, Sickle Cell Disorder, Mood and Emotional Disorders, Childhood Obesity Prevention/Breastfeeding Promotion, Prevention of Sexually Transmitted Infections Among Youth
2) Up to $400,000 in an RFA CHA070111 for Enabling Services. Such services may include, but are not limited to:
Family Navigation, Care Coordination, Family support services, Health education, Case Management, Pediatric to Adult Transition
3) Up to $400,000 in an RFA CHA070111 for Infrastructure Building. Such services may include, but are not limited to:
Parent Information Network, Needs Assessment, Planning, Policy Development, Standards Development, Information Systems
4) Allocate $2,500 to pay for up to 4 members of the CSHCN Advisory Board to attend the AMCHP conference. CHA will determine eligibility based on need and willingness to provide presentations to the advisory board and CHA.
5) Allocate up to $30,000 for Title V Staff Training used to support the professional development of program staff.
6) Allocate up to $5,000 for OCTO to provide information technology maintenance services includes help desk support and trouble shooting for technology issues. Costs are estimated at $750 per year time for an estimated 50 personal computers.
7) Allocate up to $500,000 for the existing Teen Pregnancy prevention grant.
8) Allocate up to $100,000 for the Oral Health program.
*Any additional funds will be used to cover emerging priorities and unanticipated expenses.

Maintenance of Effort/State Match
The District of Columbia has budgeted $5,298,122 in state funds in providing services to the Title V population. This amount is in excess of the maintenance of Effort and Sate match requirements.
The MOE and matching funds are used to provide nursing services to all students attending District of Columbia public and public charter schools.//2012//

/2013/
BUDGET
CHA proposes the following funding allocations to support the objectives of the Title V grant.

1) Up to $2,350,000 for management of Children and Youth with Special Health Care Needs attending DC Public and DC Public Charter Schools for Direct Services.whiich may include but are not limited to:
Pediatric Asthma Control, Sickle Cell Disorder, Mood and Emotional Disorders, Childhood Obesity Prevention/Breastfeeding Promotion, Prevention of Sexually Transmitted Infections among Youth
2) Up to$270,000 to improve access to quality comprehensive coordinated community-based systems of services for Children and Youth with Special Health Care Needs.
3) Up to $230,000 to increase the personal development and health education competencies of low income teen parents enrolled in public high schools.
4) Up to $250,000 for the design and development of an integrated, comprehensive, non-disease specific, community-based program that focuses on identifying/reducing barriers that impact the transition of special needs populations from pediatric providers to adult providers.
5) Up to $250,000 to improve access to information and care for children and youth with epilepsy by establishing formal community partnerships.
6) Allocate up to $500,000 for the existing Teen Pregnancy prevention grant.
7) Allocate up to $100,000 for the Oral Health program.
8) Up to $230,000 to provide a six-week program of five camps for 160 children with asthma.
9) Up to $130,000 to provide respite scholarships for 75 children with special health care needs to attend a 2-day weekend camp hosted by Camp Accomplish of Melwood Recreation Center.
10) Up to $240,000 to provide daily summer programming to 50children with special health care needs and their families through the ARE Therapeutic Summer Camps
11) Up to $43,000 to provide medically managed residential camp experience for children with chronic health conditions.
Any additional funds will be used to cover emerging priorities and unanticipated expenses.
//2013//

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.